The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
Elizabeth Childs, MD, Commissioner

FISCAL YEARS 2005-2007
STATE MENTAL HEALTH PLAN

September 2004

TABLE OF CONTENTS

2005 - 2007 STATE MENTAL HEALTH PLAN

"The mission of the Department of Mental Health is to improve the quality of life for adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance. This is accomplished by ensuring access to an integrated network of effective and efficient and culturally competent services that promotes client rights, responsibilities, rehabilitation and recovery."

EXECUTIVE SUMMARY

With the completed reorganization of the Executive Office of Health Human Services (EOHHS), as described fully in last year's Plan, the Department of Mental Health (DMH) is turning its attention to planning for the full integration of the Medicaid Behavioral Health Program into DMH. To recap, DMH is now in an organizational cluster, under EOHHS, with the Department of Public Health (DPH), Medicaid (acute services only) and the Division of Health Care Finance and Policy. The pairing with DPH affords increased opportunities for integration, especially in the areas of co-occurring mental health and substance abuse disorders, disease surveillance (e.g., Hepatitis C) and health and wellness initiatives (e.g., smoking reduction).

In the fall of 2003, as a consequence of the reorganization, authority for the Medicaid Behavioral Health Program (mental health and substance abuse) was transferred to the Commissioner of Mental Health. The program was formerly under the authority and control of the separate and autonomous Medicaid agency, the Division of Medical Assistance. Figuring out how to incorporate these programs culturally, fiscally and programmatically into the DMH system is a major focus of the Department's strategic planning efforts, along with a renewed focus on quality management and shared values. One major change is that the addition of the program expands the scope of DMH to take cognizance of the needs of people with mental illness who may not meet DMH eligibility criteria but need and receive mental health services through Medicaid.

In February 2004, at the request of the legislature, DMH presented a bold plan to downsize and restructure the DMH extended stay adult inpatient system, based on a careful assessment of current and future inpatient needs. The proposal included an estimate of funds that would be needed to place hundreds of discharge-ready patients into the community over an extended period of time, with proper support services, in keeping with the Olmstead decision and with DMH's long-standing commitment to community-based care. The report also recommended consolidating two of the oldest hospitals and replacing them with one new state-of–the-art facility in the central part of the state.

Mission, Goals and Objectives

DMH has two primary statutory missions: to take cognizance of all matters affecting the mental health of citizens; and to ensure that services are provided to adults, children and adolescents with serious and persistent mental illness or serious emotional disturbance. Unlike other disabilities, the provision of mental health care and treatment straddles health care and disability services, ranging from ambulatory and acute treatment to rehabilitative and recovery services. Mental illness affects *one* in *five* adults, and *one* in *ten* children; it is our society's hidden epidemic. It is an illness that is significantly stigmatized and discriminated against by traditional health care and insurance programs. Within that context, the Commissioner of DMH has articulated six goals and associated objectives for DMH in SFY'05-'07:

1. Direct the Department of Mental Health in a manner that instills the public's confidence, with an emphasis on ensuring high quality care;

- Develop understanding of and support across the Department for a strategic agenda;
- Maintain an effective partnership with constituency groups, including consumers, family members, providers, advocates, public officials and other stakeholders;
- Assess the public's interest, awareness and priorities for mental health services, including implementation of the Elimination of Barriers Initiative;
- Fully implement the Mental Health Information System to support clinical practice and operational functions.

2. Manage Department of Mental Health resources to ensure positive clinical outcomes and cost-effectiveness:
   - In coordination with EOHHS and its agencies, oversee and coordinate the integration and implementation of the Medicaid behavioral health managed care program;
   - Develop and sustain programs for assertive community treatment (PACT) throughout the Commonwealth;
   - Improve the health care status of DMH consumers.

3. Strengthen the Children's Mental Health System:
   - Increase access to community services for children and adolescents;
   - Improve the quality of care provided to children and adolescents with serious emotional disturbances;
   - Collaborate with other state agencies to facilitate the appropriate movement of children and adolescents in and out of acute care inpatient settings;
   - Improve services to children and adolescents with needs that involve multiple state agencies and special education services;
   - In conjunction with EOHHS and its agencies, oversee implementation of integrated community-based clinical and supportive services for children and their families.

4. Promote consumer rights, responsibilities and recovery opportunities:
   - Memorialize patient cemeteries and grounds at state hospitals;
   - Promote and enhance consumer involvement throughout the Department;
   - Maintain active consumer participation on citizen advisory boards;
   - Support consumer initiatives directed at monitoring the quality of DMH-funded inpatient and community services;
   - Continue to support a strong human rights program.

5. Oversee implementation of legislative reforms:
   - Monitor implementation of parity legislation and managed care laws;
   - Monitor implementation of the civil commitment law.
   - Monitor implementation of the Sex Offender Registry Information law.

6. Evaluate facility capacity needs and agency physical plant conditions to ensure dignity, high quality and appropriate allocation of resources to all DMH patients, families and staff:

- In collaboration with the Division of Capital Asset Management, undertake a study of all DMH facilities to document structural strengths and deficiencies;
- Implement recommendations of DMH Inpatient Study Report to ensure that DMH clients are served in the most appropriate settings;
- Propose recommendations for campus uses through a public process, affording input by key stakeholders such as consumers, families, staff, legislators and citizens living in communities neighboring existing facilities.

Although there are no guarantees for the future, the DMH budget for State Fiscal Year (SFY) '05 is better than expected. Excluding funding for an EOHHS initiative, the SFY'05 budget is $800,000 less than SFY'04 and is in marked contrast to the budgets of the past several years, which saw reductions of $7.8 million in SFY'02, $13.8 million in SFY'03, and $10.7 million in SFY'04. DMH will continue to monitor the gap between the supply and demand for services to inform its budget requests.

In implementing previous budget reductions, DMH made every effort to avoid cutting residential and other community-based programs for adults, adolescents and children. To the extent possible, the Commissioner held certain areas of the budget "harmless," such as child and adolescent services, homeless services, clubhouses, adult residential services and Program for Assertive Community Treatment (PACT) teams. Previous budget cuts resulted in the elimination of more than *700* positions, outpatient services for children and most adults (since coverage is usually available through insurance), and reimbursement for "free care" provided to uninsured DMH-eligible adult clients in acute hospitals. Two early retirement opportunities for state employees within a two-year period further decimated the workforce.

DMH has continued to implement its Mental Health Information System (MHIS), customizing a commercially available software system to fit its unique clinical and business environments. DMH also continues to maintain an Internet website at www.state.ma.us/dmh and responds to requests from internal and external sources. However, limited resources have prevented the expansion of the website at this time. DMH responded to more than *400* requests for help or information received through its Internet website in SFY'04. The website complements the Intranet site that DMH has operated for its own employees for five years.

The Department continues a host of other initiatives, including various collaborative efforts to promote interagency cooperation and systems integration for shared populations. One long-term goal has been to improve the interface between DMH clients and their primary care providers. Another is to collaborate with a coalition of advocates for the elderly to develop a comprehensive state plan for elders' mental health. A third is to focus on the problem of chronic homelessness, and the fourth on enhancement of mental health services throughout the state's child and adolescent services system.

There are several new and ongoing initiatives within Child and Adolescent Services. The Behavioral Health Enhancement Project is an EOHHS priority project chaired by the DMH Commissioner, to assure that children and families served by the Departments of Youth Services, Social Services, and Mental Retardation have their mental health needs promptly identified and addressed. The Suicide Prevention Task Force has convened the child-serving state agencies, providers and advocates to specifically focus on prevention of suicide and suicide attempts in residential programs. Interagency service delivery projects continue to flourish. These include the DMH/DSS Collaborative Assessment Program for children at risk of out-of-home placement; Worcester Communities of Care,

a service demonstration project funded by the Center for Mental Health Services; the Mental Health Service Program for Youth, which uses blended funds and is administered by Medicaid; and the Medicaid-administered Coordinated Family-Focused Care Initiative, also to prevent out-of-home placement. Also, the newly funded Child Psychiatry Access Project will provide primary care practitioners with access to child psychiatrists for consultation and referral. In all cases, the overarching goal is to provide high quality, culturally competent systems of community-based care.

Key Focus Areas in SFY'05-SFY'07 include:

- integrating the Medicaid Behavioral Health Programs administratively and clinically with DMH;
- developing a comprehensive quality improvement system for agency wide quality management;
- working with the administration, legislature and advocates to develop plans for a new state-of-the-art psychiatric hospital in central Massachusetts;
- working with EOHHS and its agencies to increase access to appropriate mental health services for children and adolescents in state care, to reduce the use of hospitalization and out-of-home placement, and to facilitate timely reintegration into the community;
- developing and maintaining housing programs for homeless clients and those at-risk of homelessness;
- developing and enhancing behavioral health services to individuals in the criminal justice system;
- supporting the agenda of the Youth Development Committee, with a particular focus on transitional services for older adolescents and young adults;
- improving the integration of services for clients with co-occurring disorders;
- implementing the Department's integrated Mental Health Information System and continuing to improve the accuracy and effective use of data;
- working with the State Mental Health Planning Council to ensure a climate of open and honest dialogue;
- improving communication within DMH and with the wider community;
- expanding peer support and advocacy opportunities for older adolescents and adults;
- supporting the special needs of parents with mental illness and their children.

DMH also will focus on more targeted projects. These include: continuing to find ways to serve people waiting for case management and residential services; increasing employment and educational opportunities for adults and older adolescents; expanding support for families caring for their children at home; addressing the needs of special populations, such as elders and those who are homeless or with a history of trauma, and implementing the Elimination of Barriers Initiative with high school teachers and administrators.

The State Mental Health Plan

DMH is submitting a three-year State Mental Health Plan as part of its Fiscal Year 2005 Block Grant application. This gives the Department an opportunity to lay out a more comprehensive blueprint for accomplishing its objectives.

DMH has tried to reflect the values, goals and objectives of the President's New Freedom Commission Report in the development of its Comprehensive Mental Health Plan. This Plan also includes objectives and performance targets developed for the (state) Executive Office of Health and Human Services and from the Commissioner's articulated goals for this year and beyond. Goals, objectives and performance targets for the Block Grant State Mental Health Plan were drawn from the more comprehensive plan where reliable data sources were available.

DMH continues to use the CMHS format that includes five criteria: **I**, **II**, **IV** and **V** for adults and children, and **III** for children only, with performance indicators for each criterion. The plan follows the state's fiscal year. Narrative description, including identification and analysis of the state's service system's strengths, needs and priorities, is included under each criterion, rather than as a stand-alone section. The narrative under each criterion begins by describing how the Department structures its approach to the criterion, and includes a description of those services, programs or initiatives that are applicable to all populations. That "integrated" narrative is followed, under each criterion, by separate sections that include narrative, goals, and process and performance measures that are specific to the adult system and those that are specific to the child and adolescent system. To the extent possible, DMH has selected indicators that may be measured using automated data sources to provide interested stakeholders with a "report card" displaying accomplishments, trends and gaps. Where available, targeted outcomes in the plan are related to baseline data established in SFY'03, or in '04 or '05 where appropriate. *One caveat to be noted here is that DMH is in the final stage of implementing the community data component of its new Mental Health Information System. The last DMH Area will be "live" at the end of September 2004. Therefore, we have had to rely on some assumptions on which to base future targets. If necessary, these will be adjusted when complete data for the final Area become available.* Some of the items DMH has chosen to measure are: case management, residential services, employment, access, level of functioning, client satisfaction, community tenure, smoking reduction, and options for people with mental illness who are homeless. Additional process-oriented indicators are presented as well.

THE STATE MENTAL HEALTH PLANNING COUNCIL

The State Mental Health Planning Council is a standing committee of the Statewide Advisory Council (SAC) to the Massachusetts Department of Mental Health. The SAC, established by statute (MGL c.19, section 11) and regulation (104 CMR 26.04 [4]) consists of 15 individuals appointed by the Secretary of the Executive Office of Health and Human Services to "advise the commissioner on policy, program development and the priorities of need in the Commonwealth for comprehensive programs in mental health." The Council does not have its own set of bylaws. All members of the Planning Council are nominated and appointed by SAC and include consumers, family members, legal and program advocates, providers, other state agencies, mental health professionals and professional organizations, legislators and representation from state employee unions. Membership includes family members of adults and children and members of racial, cultural and linguistic minority groups. The Council would like to recruit more representatives from various cultural and linguistic minority groups in the state. The Department provides staff to the Council.

Many members of the Planning Council also are involved in locally based participatory planning processes and with other advocacy groups. As issues arise, smaller groups function as subcommittees of the Council, with membership that includes individuals on the Planning Council as well as other interested persons. These issues include the mental health needs of elders, children and adolescents, and young adults.

Elder Mental Health Issues: Several years ago, an Elder Mental Health subcommittee of the Council produced a set of recommendations that was reviewed and approved by the Commissioner and a written curriculum on “the unique mental health needs of the elderly.” Training was provided to the field based on the curriculum. In addition, the subcommittee successfully lobbied DMH for funds to hold training conferences for professionals and advocates to improve and increase mental health services for elders. DMH has contracted with the Massachusetts Association for Older Americans every year since SFY’95 to run these conferences and will do so again in SFY'04. The recommendations are being re-examined by a group of advocates and staff interested in developing a state mental health plan for elders, in conjunction with the Executive Office of Elder Affairs.

Child/Adolescent Issues are tracked by the Professional Advisory Committee (PAC), which serves as a regular advisory group to the DMH Child/Adolescent division. The PAC reviews planning for children and adolescents and advocates with the administration and legislature on a broad range of issues related to children’s mental health. A *Youth Development Committee* that was formed to address the particular needs of transitional age youth has become a working subcommittee of the Council.

The Planning Council reviews the Department's State Plan, monitors its implementation and advocates regarding mental health system issues. It met on November 24, 2003 to review the 2003 Implementation Report, to hear a budget and program update, and to meet the two new DMH Deputy Commissioners. Calls for action by the Council included a renewed focus on planning for elders with mental illness, and on the needs of transitional age youth, including a look at their rate of participation in SEE and Clubhouse employment programs. There was also interest expressed in producing a retrospective (paper) on advances in the mental health field in the last fifty years, on which two members agreed to collaborate. The Council met on June 15, 2004

to provide input to Commissioner Childs for the new three-year State Plan (2005-2007) being prepared for submission September 1, 2004, and heard a presentation about the Department's PACT teams. The Council met on August 23, 2004 to review and approve the 2005 Block Grant application. The Commissioner asked for help with her strategic planning initiative and described her vision for reframing the role of DMH in understanding the full continuum of care. Council members raised a number of other important issues, which are explicated in more detail in their letter to the Commissioner. They were particularly concerned about the vulnerability and lack of access to services of uninsured individuals (not DMH clients) discharged from acute inpatient care, and the need to restore dental and vision benefits for adult Medicaid recipients. Although dental benefits were retained for children, access to dentists who will accept Medicaid fees has been problematic and is being addressed separately through new legislation that aims to improve the reimbursement mechanism. They reiterated their interest in the need to educate general medical doctors about mental illness, and, finally, articulated the need to provide support for community-based providers who serve people leaving the criminal justice system.

List of Planning Council Members (Table 1)

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Ellen Boley	Consumer	MDDA, NAMI	1520 Ocean St. 2-34, Marshfield, MA 02050 Tel.# 781-500-9163
John Bove	Family Member – (Adult)	Alliance for the Mentally Ill	5-6 Treetop Lane, Kingston, MA 02364 Tel.# 781-585-0798
Arthur (Buddy) Brousseau	Provider (Homeless Mentally Ill)	Mass. Shelter Providers Association	701 Main St., Worcester, MA 01610 Tel.# 508-757-0103 Fax# 508-832-6694
Rep. F.D. Antonio Cabral	Legislature	Chairman, Joint Committee On Human Services & Elder Affairs	State House – Rm.# 22, Boston, MA 02133 Tel.# 617-722-2140
*Bernard J. Carey, Jr., Executive Director	Advocate (Housing)	Mass. Association for Mental Health	130 Bowdoin St., Boston, MA 02108 Tel.# 617-742-7452 Fax# 617-742-1187
*Judi Chamberlin	Consumer	Ruby Rogers Center; Boston University	67 Magnolia St., Arlington, MA 02474 Tel.# 781-777-1154 Fax# 781-777-1154
John Chappell	State Agency	Mass. Rehabilitation Commission	27 Wormwood St., Boston, MA 02110 Tel. # 617-204-3620 Fax.#617-727-1354

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
James Chengelis, M.D.	Professional (Addiction Medicine)	Melrose-Wakefield Hospital	88 Browne St., Brookline, MA 02446 Tel.# 617-232-6592
Deborah Delman	Consumer	M*Power	197 Ashmont St., Dorchester, MA Tel.# 617-929-4111
Jon Delman, Executive Director	Consumer	Consumer Quality Initiatives, Inc	197 Ashmont St., Dorchester, MA 02124 Tel.# 617-929-4400
Colleen Doherty	State Agency/Employee Union	Dept. of Mental Health/ SEIU-Local 509	400 Talcott Avenue Watertown, MA 02472 Tel#., 617-924-8509
Peter Dulchinos	Family Member – (Adult) (Child Advocate)	Statewide Advisory Council	17 Spaulding Rd., Chelmsford, MA 01824 Tel.# 978-256-5256
Elena Eisman, Ed.D., Executive Director	Professional	Mass. Psychological Association	195 Worcester St.-#303, Wellesley, MA 02401 Tel.# 781-263-0080
Joseph Finn	Advocate (Homeless)	Mass. Housing & Shelter Alliance	5 Park St., Boston, MA 02108 Tel.# 617-367-6447 x14 Fax #617-367-5709 x14
Tobias (Toby) Fisher, Executive Director	Advocate (Family Members)	Alliance for the Mentally Ill of Mass, Inc.	400 West Cummings Park - Suite #6650 Woburn, MA 01801 Tel.# 781-938-4048 Fax # 781-938-4069
Robert Fleischner	Advocate (Legal/Human Rights)	Center for Public Representation	22 Green St., Northampton, MA 01060 Tel.# 413-586-6024 x265
Sally Fogerty	State Agency	Department of Public Health	250 Washington Street Boston, MA 021 Tel# 617-624-6090
Peter Foulkes	Consumer	Genesis Club	1050 Main St. Apt. 815 Worcester, MA 01603 Tel. # 508-797-9015
Marta Frank, Executive Director	Advocate (Elders)	Boston Senior Home Care & Boston Elder INFO	110 Chauncey St., Boston, MA 02111 Tel. # 617-451-6400

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Susan Getman	State Agency	Department Social Services	24 Farnsworth St., Boston, MA 02210 Tel.# 617-748-2348 Fax # 617-439-4482
Carol Gramm	Family Member (Child)	PAL	15 Court Sq. - #1060, Boston, MA 02108 Tel. # 617-542-7858 x202
Mary C. Gregorio, C.R.C., Director	Provider (Clubhouse/Rehab)	U.S. Psychosocial Rehab Assoc./Center House, Inc.	31 Bowker St., Boston, MA 02114 Tel.# 617-788-1002 Fax # 617-788-1080
Christine Griffin, Executive Director	Advocate (Legal)	Disability Law Center	11 Beacon St., Suite 925 Boston, MA 02108 Tel# 617-723-8455 Fax# 617-
Greg Guillano	State Agency	Executive Office of Elder Affairs	One Ashburton Place, Boston, MA 02108 Tel. # 617-222-7464
Phil Hadley	Family Member - (Adult)	Alliance for the Mentally Ill of Mass., Inc.	400 West Cummings Park - Suite#6650 Woburn, MA 01810 Tel. #781-938-4048 Fax #781-938-4069
Kathleen Hart	State Agency	Department of Education – Office of Special Services	350 Main St. Malden, MA 02148 Tel. # 781-338-3734
Marjorie Harvey	Advocate (Elders)		80 Park St. - #23, Brookline, MA 02446 Tel. # 617-735-9477
Sandra Hawes	State Agency	Department of Housing/ Community Development	One Congress St., Boston, MA 02114 Tel. # 617-727-7004 x521
Richard Hogarty, Ph.D.	Family Member – (Adult)	UMass/McCormack Institute	193 Green St., Marblehead, MA 01945 Tel. # 781-631-7379
Dana Holley	Professional	Mass. Association of Social Workers	53 Hillside Ave., Bedford, MA 01730 Tel. # 617-484-0193
Tedi Hughes	Professional	Nurses United for Responsible Services	328 Prospect St., Cambridge, MA 02139 Tel. # 617-636-2560

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Anthony Jackson, M.D.	Professional	New England Council of Child/Adolescent Psychiatry	31 Woodlawn Ave., Needham, MA 02492 Tel. # 508-650-7716 Fax #781-449-2787
Robert Kinscherff, Ph.D., J.D.	State Agency (Criminal Justice)	New Chardon Court House - Juvenile Court Clinics	3 Center Plaza Boston, MA 02108 Tel. # 617-788-6550
Lisa Lambert	Family Member – (Child)	PAL/PAC	59 Temple St. - #664, Boston, MA 02111 Tel. # 617-542-7860 x203 Fax #617-542-7832
Frank Laski, Executive Director	Advocate (Legal/ Human Rights)	Mental Health Legal Advisors Committee	294 Washington St., Boston, MA 02108 Tel.# 617-338-2345 x23
Pat Lawrence	Family Member – (Adult)	Alliance for the Mentally Ill	8 Elliot Rd. Lynnfield, MA 01940 Tel. # 781-592-2401
Nancy Blake Lewis, Executive Director	Family Member – (Adult) (Child Advocate)	Refuah	15 Hemlock Terrace, Randolph, MA 02368 Tel. # 781-961-2815
Dennis McCrory, M.D.	Professional (Rehabilitation)	Friends of the Psychiatrically Disabled	6 Ridge Ave. Newton Ctr, MA 02469 Tel. # 617-471-9990
Joan Mikula	State Agency	DMH - Children/ Adolescents	25 Staniford St., Boston, MA 02114 Tel.# 617-626-8086 Fax # 617-626-8058
Michael Norton	State Agency	DMH -Medicaid Behavioral Health Programs	250 Washington St., Boston, MA 02108 Tel.# 617-624-5670 Fax# 617-624-5698
Tim O'Leary	Advocate (Housing, Anti-Stigma)	Mass. Association for Mental Health	130 Bowdoin St., Boston, MA 02108 Tel.# 617-742-7452 Fax# 617-742-1187
Wayne Perry	State Agency	Developmental Disabilities Council	1150 Hancock St. Quincy, MA 02169 Tel.# 617-770-7676 x106 Fax #617-770-1987
Maureen Piraino	Advocate (Elders)	Boston Partnership for Older Adults	99 Chauncy Street -#602 Boston, MA 02111 Tel#617-482-7778

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Gailanne Reeh	Advocate (Children/ Elders)	Arbour Associates, Inc.	15 Court Sq., #1050, Boston, MA 02108 Tel.# 617-227-8829
Ruth Robinson	Advocate (Elders)		50 Wheeler Rd., Newton, MA 02159 Tel.# 617-969-5750
Lisa Simonetti, Advocacy Liaison	Professional Organization	Mass. Psychiatric Society	PO Box 136 Boston, MA 02133 Tel.# 617-742-9772 x14 Fax #617-742-9855
Jessel-Paul Smith	Consumer	Mass. Consumer Satisfaction Team, Inc.	197 Ashmont St., Dorchester, MA 02124 Tel.# 617-929-4411 Fax# 617-929-4128
Sen. Susan C. Tucker	Legislature	Chairwoman, Joint Comm. on Human Services & Elder Affairs	State House, Rm.416-A, Boston, MA 02133 Tel.# 617-722-1612 Fax #617-722-1058
Sandra Vickery	Advocate (Elders)	Bourne Council on Aging	P.O. Box 806 Monument Beach, MA 02553 Tel#508-759-0653
Beverly Waring	Provider (Homeless Mentally Ill)	Tri-City Mental Health Center	10 Cabot Rd. Medford, MA 02155 Tel. # 781-397-2097 Fax# 781-393-6551
Donna Welles, Executive Director	Family Member – (Child)	PAL/PAC	59 Temple Pl., Suite 664 Boston, MA 02111 Tel.# 617-542-7858
Anne Whitman	Consumer	Cole Resource Center, McLean Hospital	4 Dana Place, Cambridge, MA 02138 Tel.# 617-855-3298
John D. Willett	Family Member – (Child)		14 Cottage St., Apt. C Pepperell, MA 01463 Tel.# 978-858-4462

* Co-Chair of Planning Council

Planning Council Composition by Type of Member (Table 1A)

Type of Membership	Number	% of Total Membership
TOTAL MEMBERSHIP		
Consumers/Survivors/Ex-patients (C/S/X)	7	13
Family Members of Children with SED	4	7.5
Family Members of Adults with SMI	6	11
Others (not state employees or providers)	20	38
TOTAL C/S/X, Family Members & Others	37	
State Employees	13	_53_# (24.5)%
Providers	3	
TOTAL State Employees & Providers	16	_53_# (30)%

Public Comments on State Plan

The State Mental Health Planning Council, a comprehensive, 52-member body comprising all of the stakeholders with an interest in mental health services, has been the primary reviewer of the annual State Mental Health Plan and Implementation Report for many years. However, in addition to the Plan's review by the Council, DMH intends to expand the scope of input and review of the Plan to include any and all interested members of the general public through the following activities:

1. DMH will post the Plan prominently on its internal and external websites and will solicit and review all comments received. If necessary, the Plan will be amended to reflect changes made as a result of this process.

2. DMH will alert interested parties to the website posting through direct mailings to all those on its "Interested Parties" list. This includes other state agencies, legislative leaders, all of DMH's citizen advisory boards, legal advocates, provider groups, professional organizations, consumer and family groups and interested individuals.

Description of the State Service System

Demographic Data

Massachusetts is a relatively small, industrial state with a net land area of 7,838 square miles and an average of 810 people per square mile. In 2003, it had a population of 6,433,422, a 3.3 percent increase over 2000, and ranks 13th in population and 45th in area among the states. More than half of the total population lives in the Greater Boston area. The state is 190 miles, east to west, and 110 miles, north to south, at its widest parts. According to the 2000 census, 84.5 percent of the population was white (81.9 percent reported themselves as white not of Latino/Hispanic origin), 5.4 percent African-American, .2 percent Native American, 3.8 percent Asian, 2.3 multiracial and 6.8 percent Hispanic. In recent years, there have been significant increases in immigrants from Southeast Asia, Central America, the Caribbean Islands and the former Soviet Union.

Although there are some towns in the western, central and southeastern (Cape Cod and offshore islands) parts of the state that are not attached to a Metropolitan Statistical Area, more than 75 percent of the population in the Department of Mental Health's (DMH) Western and Central Massachusetts Areas are attached to identified urban centers. Each of the DMH local service sites has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the local service sites has a population density below 100 people per square mile. As a result of this demographic profile, DMH does not have an official definition of "rural" or a separate division or special policies for adults, children or adolescents who reside in the less densely populated areas of the state. However, access to services in these areas continues to pose a challenge to Area planners and providers.

Historical Perspective on Mental Health Care: a Mission Evolves

Massachusetts has been a leader in caring for people with mental illness since it built the first public asylum in America. The Worcester State Hospital opened in 1833, serving as a model that other states soon followed. Over the next century, Massachusetts established a network of public hospitals, responding to needs as they arose. The Community Mental Health Centers Act of 1963, signed by President John F. Kennedy, espoused treating people with mental illness locally, rather than in large isolated state hospitals, and led to the construction of federally funded community mental health centers across the country, including several in Massachusetts.

Mental health care reform in Massachusetts has grown and changed since 1966, when the legislature enacted the Comprehensive Mental Health and Retardation Services Act. Its purpose at the time was to decentralize DMH and set up a network of services within each community so that people could receive help close to their homes.

The process to increase the availability and quality of community programs was enhanced in 1978 when the Brewster consent decree was initiated. The consent decree asserted the right of mentally disabled persons in the Western Massachusetts Area to receive care in the least restrictive setting. It signaled a shift in the locus of treatment from institutional to community settings and aimed to reduce the Northampton State Hospital census. As a result, significant resources were directed to this DMH Area to implement the decree, accomplished through contracts with local providers. It became a

model for community-based service delivery statewide. The Department was disengaged from the consent decree in 1992. In 1984, Executive Order 244 prohibited children and adolescents (under 19) from being treated on adult inpatient wards of state hospitals and led to the creation of new residential prototypes and the privatization of most care for children under 19. On June 22, 2000, Governor Cellucci issued Executive Order 422, which replaces Executive Order 244 and allows placement of a 17 or 18 year old on an adult inpatient unit of a state-operated hospital or community mental health center when:

- A judge has issued an order for commitment to a mental health facility;
- An individual has been committed to the Department of Youth Services and DMH has determined that placing the individual on an adolescent unit would create a likelihood of serious harm to the person or others and/or the individual is in need of stricter security than is available on an adolescent mental health unit.

Other executive and legislative initiatives between 1985 and 1987 expanded case management and emergency services, and sought to improve the state hospitals and create 2,500 new housing units for adults awaiting community placement. Severe budget cuts in SFYs'90 and '91, however, impeded progress toward fully implementing this community housing initiative. Meanwhile, Chapter 599 (Acts of 1986) split DMH into separate departments of mental health and mental retardation, effective July 1, 1988. This legislation also created a primary mission for DMH to "provide for services to citizens with long term or serious mental illness and research into the causes of mental illness." In 1989, a lengthy and inclusive process involving clients, family members, advocates and mental health professionals culminated in a new policy on priority clients that further defined the Department's mission and targeted service population. This policy was replaced in July 1999 with the issuance of the Department's new service planning regulations. The regulations define "DMH client" and establish clinical and other criteria for receiving DMH services in the community. However, individuals who meet the clinical criteria are eligible for admission to a DMH inpatient facility, whether or not they ultimately meet the criteria for DMH community services.

In October 2003, authority for the Medicaid Behavioral Health Program (including acute mental illness and substance abuse services and emergency screening services) was transferred to the DMH Commissioner. This occurred as part of a major reorganization of the Executive Office of Health and Human Services into service-related clusters. The "Health" cluster includes DMH, the Department of Public Health (the state's substance abuse agency), the Division of Health Care Finance and Policy (rate setting), and the acute services division of Medicaid. Although DMH community services are still targeted to its previously defined population of adults with serious mental illness (SMI) and children with serious emotional disturbance (SED), Medicaid services reach a broader clientele of people who need mental health care and meet medical necessity criteria, but may not meet the DMH criteria for SMI or SED. One of the important goals and challenges over the next three years is to integrate the Medicaid Behavioral Health Program into DMH. This is consistent with the overall statutory mission of DMH to "take cognizance of the mental health needs of the citizens of the Commonwealth," but expands its previously defined service mission. Similarly, the Department's role in disaster mental health planning, in collaboration with DPH, also extends the Department's scope.

In January 1991, the new governor, William Weld, appointed a "Special Commission on Consolidation of Health and Human Services Institutional Facilities" to respond to the impetus for community-based mental health care and the Commonwealth's budget crisis. With the advent of new medications and a renewed emphasis on community-based care, the state hospital census in Massachusetts had dropped dramatically, from 23,000 in the 1950s to about 2,300 in 1991. Even so, the new administration and the commission's June 1991 report became the catalysts for major changes. As a result of this report and a subsequent study of children's services, DMH closed three adult state hospitals - Metropolitan, Danvers and Northampton, and the Gaebler Children's Center - the only state-operated inpatient facility for children under age 14 - between January 1992 and August 1993. As required, all patients in those facilities were transferred or discharged to "equal or better" living situations and the Department tracked these patients to assure accountability. DMH "replaced" the inpatient services formerly provided to adults and children in the state hospitals with a variety of innovative and community-oriented programs, funded with about $70 million saved from the hospital closings. In addition, DMH contracted directly with a number of private psychiatric and general hospitals and downsized a number of its inpatient units in state-operated community mental health centers (CMHCs) to provide acute inpatient care for those DMH clients who would previously have been served in state hospitals.

The years after the hospital closures were spent creating an infrastructure to support the new system, including the development of quality and utilization management systems and standards of care, rebuilding a strong Area structure, expanding the community system and accommodating to the new managed care environment. Also during this time, DMH established an Office of Consumer and Ex-Patient Relations, the second such office in the country.

In July 1999, DMH issued the last section of its revised code of regulations, thus providing the general public and vendors who do business with DMH an up-to-date interpretation of the statutes that pertain to mental health. These new regulations recognize that many of the services now delivered to clients are contracted, rather than state-operated, and appropriately eliminated many burdensome requirements. The regulations outline the Department's authority, mission and organizational structure, citizen participation, licensing and operational standards for inpatient facilities (DMH-operated and other licensed inpatient facilities) and community programs, and standards for service planning, fiscal administration, research, investigation procedures, and designation and appointment of professionals to perform certain statutorily authorized activities. An additional chapter was added to the Department's regulations in January 2001 that codified the requirements for conducting Criminal Offender Record Checks on potential employees, trainees and volunteers of DMH or its vendor agencies.

In May 2003, DMH again seized an opportunity to expand community options for discharge-ready clients by closing Medfield, another of its antiquated hospitals, and placed a total of *255* clients, from Medfield and other sites across the state, into the community, with appropriate support services, using savings derived from the closing. In February 2004, DMH presented a bold plan to the legislature, which proposed a downsizing and restructuring of the DMH extended stay adult inpatient system. The recommendations were based on a careful assessment of current and future inpatient needs. They included an estimate of funds that would be needed to place hundreds of patients into the community over an extended period of time, with proper support services, in keeping with the Olmstead decision and with DMH's long-standing

commitment to community-based care. The Report also recommended consolidating two of the oldest hospitals (including Worcester State Hospital, the first public asylum in the country), and replacing them with one new state-of–the-art facility in the central part of the state. The details of the plan and the site of the new hospital are yet to be determined, but the dialogue has begun. The legislature has established a special commission to study the feasibility of the proposal. Their report is due April 1, 2005.

Medicaid Managed Care

The Division of Medical Assistance (the state's Medicaid agency - DMA) applied for and received waivers from the Health Care Financing Administration (now CMS) to pursue a managed care initiative. In July 1992, DMA contracted with a for-profit vendor, Mental Health Management of America, Inc. (MHMA), to manage its behavioral health care program for those Medicaid recipients, including DMH clients who were also Medicaid recipients, enrolled in its Primary Care Clinician Program (PCCP). Medicaid recipients enrolled in HMOs or covered by Medicare or other insurance and uninsured DMH clients were not included. This "carve-out" contract covered the entire state.

In July 1996, DMH signed an Interagency Service Agreement (ISA) with DMA whereby DMA agreed to expand eligibility for its behavioral health care "carve-out" in order to purchase acute inpatient services for adult DMH clients who are uninsured (this provision was eliminated with FY'03 budget cuts), and assure access to such services for children and adolescents. Hospitalization for children is funded either through private insurance, Medicaid or the uncompensated care pool. To the extent that funds are available, uninsured adults also are covered by the state's uncompensated care pool, which is jointly funded by the hospitals, HMOs/insurers and the Commonwealth. DMA also agreed to purchase emergency and additional diversionary services, except in DMH's Southeastern Area where DMH continues to maintain state-operated services. Also in July 1996, a new mental health and substance abuse (MH/SA) vendor, the Massachusetts Behavioral Health Partnership (MBHP), was selected to manage this acute system, replacing MHMA. After a re-procurement process in the spring of 2001, MBHP was selected by DMA to continue managing the MH/SA program.

With the implementation of the ISA, DMH became the provider primarily of extended stay inpatient services and continuing care community-based services. DMH terminated its contracts with the former acute "replacement" inpatient units and emergency service programs, which became part of the vendor's network. However, DMH continues to operate 16-bed acute inpatient units at three of its CMHCs and accepts a limited number of acute admissions at other CMHCs in the Metro Boston Area, one of which is affiliated with a public health hospital.

The Department has developed a good working relationship with MBHP to implement the ISA. DMH and DMA exchange data to ascertain the use of acute care services by DMH clients that ultimately document DMH's financial obligation to DMA and forecast savings available for community investment. Monitoring the use of both acute and continuing care services allows DMH and DMA to target dollars and services where they are needed.

DMH - The State Mental Health Authority

As the State Mental Health Authority, DMH worked with DMA to develop the Request for Responses (RFR) for the 1992, 1996 and 2001 procurements and participated actively in selecting the vendors to manage the behavioral health managed care program.

The RFR forms the basis of the contract between DMA and its MH/SA vendor. It includes an array of program standards, clinical criteria and protocols, policies, performance incentives and other purchasing specifications to ensure that both DMA and the vendor maintain the quality of care that DMH had previously been able to assure through its own acute units and emergency service program contracts. As mentioned previously, the transfer of authority for the Medicaid Behavioral Health Program to DMH will have significant implications for this system of care. DMH expects to play an even stronger role in setting standards, maintaining access and assuring quality.

The DMH system of care emphasizes treatment, clinical services, rehabilitation and recovery. The central aim of service delivery is to integrate public and private services and resources to provide optimal community-based care and opportunities for clients. DMH works toward reducing the need for unnecessary hospitalization and out-of-home placement by improving integration of acute diversion with community support programs, including collaboration with the Department of Social Services, DMA and its MH/SA vendor to assure an adequate and coordinated network of appropriate options. In addition, DMH has a well-established process in place that clearly defines the eligibility process, identifies the population to be served, and establishes a wait list for services. People eligible for DMH services are moved from waiting lists and into community programs in a reasonable manner, as resources permit. The array of DMH-provided community services is described under Criterion I.

Defining the Target Population

As previously noted, DMH has had a policy defining "priority clients" since 1989. The policy was developed in response to the legislative mandate to narrow the service mission of DMH to adults with serious mental illness and children with serious emotional disturbance. However, with the signing of the ISA between DMH and DMA in July 1996 formalizing DMH's primary responsibility for continuing rather than acute care, DMH established a more consistent and reliable method of determining eligibility for its community services. Clinical teams of DMH eligibility determination specialists were identified and trained and functional assessment instruments were selected for use with adults and children. The eligibility determination process is being continuously evaluated and refined to ensure that clients do not fall through the cracks when transferring from the DMA managed behavioral health care vendor (acute care) to DMH (extended stay/continuing care) and to ensure that individuals who need DMH services get them. The DMH Child/Adolescent division has used the CAFAS (Child and Adolescent Functional Assessment Scale) since July 1996 to assess functional impairment of children/adolescents applying for continuing care community services. Also, children's case managers administer the CAFAS at the time of Individual Service Plan (ISP) renewal/reauthorization. Adults are assessed using the CERF-R (Current Evaluation of Risk and Functioning-Revised) - a DMH-designed assessment instrument. The CERF-R is used at the time of inpatient admission, three and six-month review, annually and at discharge. It is used also for case managed adult clients in the community to assess each client's functioning at the time of ISP development and at least annually at the time of ISP renewal and reauthorization.

Organization of the Department of Mental Health

It is important to note that although Massachusetts has designated counties, the counties do not fund, oversee or provide public mental health services. These

responsibilities are carried out primarily by DMH, under the auspices of the Executive Office of Health and Human Services (EOHHS). The reorganization of EOHHS and its 15 constituent agencies in SFY'04 paired DMH with the Department of Public Health (DPH - the agency with responsibility and main funding for substance abuse programs and services), Medicaid (acute services only), and the Division of Health Care Finance and Policy in the Health cluster. Two other EOHHS agencies, the Department of Social Services (DSS) and the Department of Youth Services (DYS/juvenile justice), housed in another EOHHS cluster, are responsible for arranging acute care mental health services for children in their care or custody through MBHP or private insurance; DMH provides continuing care services and clinical advice. In SFY'01, DMH and DSS jointly designed an intensive residential service, managed by DMH, specifically for some seriously behaviorally disordered children in the DSS system.

DMH is organized into six geographic Areas, each of which is managed by an Area Director. Each Area also has a full-time medical director, part-time child psychiatrist, and a director of child/adolescent services, and is further subdivided into Local Service Sites. There are *31* Sites statewide, each of which is overseen by a Site Director/Case Management Supervisor. The Sites provide case management and oversee an integrated system of state and vendor-operated adult and child/adolescent mental health services. Most service planning, budget development, program monitoring, contracting, quality improvement and citizen monitoring services emanate from Site and Area offices.

The central office of DMH, located in Boston, has three divisions in addition to the Commissioner's office - Mental Health Services (program operations), Clinical and Professional Services, and Management and Budget. It coordinates planning, sets and monitors attainment of broad policy and standards, and performs certain generally applicable fiscal, personnel and legal functions, although the EOHHS reorganization entails centralizing the management locus of certain functions to EOHHS, such as human resources, information technology, budget, revenue and accounting. Some specialized programs, such as forensic mental health services, adolescent extended stay inpatient units, and child and adolescent intensive residential treatment programs are managed centrally by DMH. The Department allocates funds from its state appropriation and federal block grant to the Areas for both state-operated and contracted services, which include the three remaining state hospitals, five community mental health centers (CMHCs) with inpatient units, adult extended-stay units at two public health hospitals, contracted adult and adolescent extended-stay inpatient units and community-based services.

All of the state hospitals, CMHCs, adolescent inpatient units, and child and adolescent intensive residential treatment programs are accredited by the Joint Commission on Healthcare Organizations (JCAHO) and certified by CMS (Center for Medicare and Medicaid Services, formerly HCFA). DMH has the statutory responsibility for licensing all non state-operated involuntary general and private psychiatric inpatient units and adult residential programs in the state. Children's community residential programs are licensed by the Office of Child Care Services.

DMH collects statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient facilities (adults, children and adolescents) and intensive residential treatment programs (children and adolescents). Through its licensing and contracting authority, the Department provides direction, technical assistance and clinical expertise and consultation on state-of-the-art practices designed to

reduce the utilization of these high-risk interventions. Review of the facility's restraint data and a discussion of prevention, early intervention and pro-active planning efforts have been a focus of each two-year licensing visit and the more frequent contract monitoring visits. The DMH licensing division and Child/Adolescent Services division provide ongoing consultation and assistance to these facilities and programs. DMH has begun a successful initiative to reduce and eventually eliminate the use of restraint and seclusion in its licensee and state-operated facilities.

Each Area and Site has a citizen advisory board, appointed by the commissioner and comprised of consumers, family members, professionals, interested citizens and advocates. They assess needs and resources and participate in planning and developing programs and services in their geographic domain. A Statewide Advisory Council (SAC), appointed by the Secretary of EOHHS and comprised of consumers, family members, professionals, interested citizens and advocates, receives and analyzes data pertaining to the entire system and advises the Commissioner on mental health policy and priorities. The State Mental Health Planning Council is established as a subcommittee of the SAC. In addition, there is a statewide Human Rights Advisory Committee, and each hospital has a board of trustees appointed by the Governor and a trustee's seat on the Area board in the DMH Area where the hospital is located. Although not mandated by statute or regulation, there also is a Professional Advisory Committee on children's mental health, comprised of advocates, professionals, family members and state agency representatives, a Consumer Advisory Council and two advisory groups to the Office of Multicultural Affairs.

Research

To carry out its statutory research mission, DMH funds two Centers of Excellence, one in Clinical Neuroscience and Neuropharmacology (Harvard Medical School) and one in Behavioral and Forensic Sciences (University of Massachusetts Medical School). Both centers are conceptualized as Public/Academic Liaisons, a model of interaction for clinical research championed by the Center for Mental Health Services. The centers are structured independently with DMH and an accredited academic institution. They are expected to meet mutually agreed upon standards and to leverage DMH funds to procure outside research grants. The Centers provide general research assistance, as well as case consultation to DMH-operated or contracted programs, and DMH Central Office, on request. In addition, DMH has provided a small amount of seed money to a diverse group of consumers, family members, academics and DMH staff to explore the development of a consumer-directed Participatory Action Research Center. This Center would specialize in translating community-based research into local practice and policies.

In addition to the Centers of Excellence, DMH was the major contributor to a $12 million neuropsychiatric research facility affiliated with the University of Massachusetts Medical School and connected physically to Worcester State Hospital. The facility resulted from 12 years of planning and studies the biological causes of mental illness. The facility was funded through state dollars ($7.8 million) and private donations, including a $2.5 million gift, and opened officially on May 1, 2000.

Finally, as required by federal law and state regulation, the Department's Central Office Research Review Committee reviews and must approve all requests by researchers to use DMH clients, past or present, as research subjects.

DMH has issued two "Mortality Reports," in June 2001 and October 2002. A third is planned for release in September 2004. These reports have drawn attention to the fact that adults with serious mental illness are more likely to die from cardiac, respiratory and other medical diseases than their counterparts of the same age without mental illness in the Commonwealth and in the United States. These reports have strengthened the DMH Commissioner's resolve to address the disparity in health outcomes between DMH clients and the general population by investing in health and wellness initiatives for DMH clients.

Legislative Activities

In *May 2000*, Massachusetts became the 31st. state to enact "parity" legislation, which guaranteed that mental health benefits would be equal to physical health benefits provided through medical insurance. The law took effect in January 2001. The Division of Insurance (DOI) works with DMH and the Office of Patient Protection at DPH to provide guidance to providers, monitor the law's implementation and resolve complaints. Also, in the past year, the DOI began to require HMOs to report on utilization of behavioral health care services by children and adolescents. In *July 2000*, a law was enacted that changed the civil commitment process for people with mental illness who are involuntarily admitted to a hospital due to risk of harm to self or others. This aligned Massachusetts with most other states regarding the length of involuntary hospitalization prior to a judicial review, it strengthened due process safeguards and reflected advances in clinical practices.

A new interpreter law, passed in *April 2000* and effective July 2001, required competent interpreter services for all people seeking emergency or acute health care services, including psychiatric care. In *November 2002*, the legislature passed a custody relinquishment act, an amendment to the DSS statute, which clarifies that parents who sign voluntary agreements in order to get treatment for their children, do not have to give up custodial rights. Finally, a *2003* amendment to the statute that created the Sex Offender Registry Board (SORB) provides that "[n]o sex offender shall be released from custody unless such registration has been filled out, signed and mailed to the [SORB]." The law places certain requirements on custodial agencies for giving notices and providing registration data to the SORB concerning individuals in their custody. DMH is considered a custodial agency for purposes of individuals (patients) admitted to the facilities it operates. DMH has taken steps to ensure that its facilities comply with this requirement when discharging patients who are listed in the Registry.

Finally, in *SFY'04*, the legislature reauthorized the loan fund that provides $100 million in new bond funds for housing for DMH and DMR clients.

CRITERION I: Comprehensive Community-based Mental Health Service System

A comprehensive, community-based system of mental health care for adults with serious mental illness and children and youth with serious emotional disturbance, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental and other support services, which enables individuals to function in the community and reduces the rate of hospitalization.

Identification and Analysis of the Service System's Strengths, Needs and Priorities

Issues Common to Adults, Children and Adolescents

A Community-based System of Care

Massachusetts has provided community-based care since 1966, when the legislature created the structure for an area-based system. Until 1991, however, a disproportionate share of the Department's resources was tied up in the state's antiquated psychiatric hospitals. Since that time, five hospitals have been closed (four adult and the remaining children's center), savings have been reinvested in community programs and infrastructure, clients and other stakeholders have increased their participation in planning and policy development, and area-based management has been anchored by statewide standards. These changes have created an enhanced and vigorous community-based system of care for adults, children and adolescents.

DMH currently serves about *26,000* individuals a year, including adults, children and adolescents, through acute (adults only) and extended stay inpatient care, intensive residential treatment, emergency services, case management and other community and rehabilitative services. On July 1, 1996, under the terms of an Interagency Service Agreement (ISA) between DMH and the Division of Medical Assistance (DMA), DMA began to purchase, through a managed behavioral health care vendor, acute care and most emergency services on DMH's behalf for DMH clients, including those who are uninsured. Payment for acute care hospitalization of uninsured DMH clients was discontinued due to budget cuts in SFY'03. As a result of the ISA, DMH established a uniform eligibility determination process to enable each agency to identify the clients for whom it had responsibility. As previously noted, Medicaid's behavioral managed health program has recently come under the authority of DMH.

Because a majority of DMH clients are also Medicaid recipients and have been receiving most of their acute services through Medicaid's behavioral "carve-out" since 1992, implementation of the ISA has led to improved use of DMH resources and better access to entitlements for DMH clients. Cost savings from the purchase of acute care services by DMA, through its behavioral health care vendor (MBHP), are designated for DMH expansion of its continuing care system, primarily for community-based services. Services developed or improved have included: expanded residential options for children and adults; in-home treatment for children and adolescents; flexible supports for adults and children in the community; case management services; dual diagnosis treatment;

clubhouses; day treatment; skills training; and supported employment. Total savings realized since the initial ISA and invested annually in community programs are about *$19.37* million. The expansion of the continuing care community system is central to ensuring that clients move appropriately through the mental health system. In addition, these funds have been distributed in a way that addresses historic inequitable resource distribution among Areas. In SFY'01, the legislature appropriated *$10* million to EOHHS to develop services for children and adolescents with serious emotional disturbance unable to be discharged from hospitals for lack of appropriate placements ("stuck kids"). DMH and DSS jointly developed two Behavioral Intensive Residential Treatment programs for difficult-to-manage adolescents in DSS custody and created Enhanced Therapeutic Foster Care for younger children in DSS custody. DMH increased funding for residential placements. In addition, funds were used to increase child psychiatry staff time in each DMH Area and for DSS to hire a clinical coordinator for each of its Regions to facilitate hospital discharges.

Clients also have benefited from the DMH/DMA initiative through improved access to entitlements. A primary benefit of enrollment in a publicly funded health insurance plan such as Medicaid is greater access to primary health services.

DMH has recognized the need to prioritize access to services for special populations, such as elders, people who are deaf, hard of hearing or late deafened, parents with mental illness, people involved in the criminal justice system and disaster victims. An equally critical priority is improving timely access to services for eligible DMH clients.

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care. When DMH submitted its last three-year plan, in September 2001, there were four DMH-operated psychiatric hospitals, two DMH/DPH facilities, five CMHCs with small inpatient units for adults, three adolescent units, and one adult and one latency age contracted unit.

Since 1992, DMH has closed five state hospitals, including the state-operated children's center, and phased out the contracted latency age unit, transferring responsibility for acute care from the public to the private sector. In addition to reducing the number of beds in the DMH system, this also has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community. The expansion of diversionary services and other community supports, and the entrance of behavioral managed care have substantially reduced the rate of hospitalization. DMH, DSS and DMA are engaged in a major effort to significantly expand and enhance community-based services for children and adolescents that may reduce the need for hospitalization.

As of August 2004, DMH has *996* inpatient beds. These are spread among three DMH-operated state psychiatric hospitals, five community mental health centers (CMHCs), one state-operated and two contracted adolescent units housed in state psychiatric hospitals, mental health units in two public health hospitals, and one contracted adult unit in a private hospital. The total capacity, which includes beds for forensic patients, includes *948* adult beds and *48* adolescent beds. All are extended stay beds with the exception of three 16-bed CMHC acute units. Children and adolescents receive acute inpatient care in private or general hospitals, with the exception of some forensic admissions to the DMH contracted units. The number of state hospital admissions, including forensic admissions for adults (19+) in SFY'04 was *19.92* per 100,000 population (SFY'03 rate was 21.58). The total number of days of hospitalization

in state hospitals for adults per 100,000 population in SFY'04 was *5,923* (SFY'03 rate was 6,157). The corresponding rates for adolescents in the DMH extended stay units in SFY'04 were *5.55* admissions per 100,000 population and *886* days per 100,000 population.

Case Management

Since it developed its case management policy in 1987, DMH has acknowledged the importance of case management and individual service planning in connecting clients to needed services, but has not had sufficient resources to assign a case manager to each eligible client. Therefore, the policy established priority for state-operated case management services for those adults with serious, long-term mental illness and children with serious emotional disturbance who were being discharged from inpatient stays or with a history of repeated psychiatric hospitalizations, homeless with mental illness, or unable to meet life support needs of shelter, food, clothing and self-care. They also were mandated specifically for children deemed eligible for DMH continuing care community services. Case management was organized primarily as a "brokerage" model.

In SFY'98 and SFY'99, DMH undertook a thorough examination of the DMH case management system. This project began as DMH was revising the remaining section of its regulations on service planning (SP) and occurred at the same time that a uniform process to determine eligibility for DMH continuing care community services was being implemented. The SP project involved a task force, focus groups and extensive public input from all of the Department's stakeholders and succeeded in defining a "DMH client" in a behavioral managed mental health care environment. After significant public comment and further review, the final regulations were promulgated on July 1, 1999 with a phased-in implementation process planned. The regulations state that every individual who meets the clinical criteria, is determined to be in need of at least one existing DMH continuing care community service, and has no other means of obtaining that service will be eligible for DMH community services, including case management. Case management remains a state-operated service. Clients are assigned a case manager based on the intensity of their need and as resources permit. Subject to available resources, every DMH client is eligible for DMH case management. The only exceptions to this rule are adult clients (n = *600*) assigned to Programs for Assertive Community Treatment (PACT) teams who receive intensive case management as part of the program design. While it is clear that DMH does not have the resources presently to provide a case manager for every eligible client, a process has been developed to triage clients to determine their priority of need. Clients waiting for case management or residential services are often assigned to other community services.

Consumer Initiatives

DMH has had an Office of Consumer and Ex-Patient Relations (OCER) since 1991. OCER oversees a Consumer Advisory Council, manages a toll-free information line, ensures that consumers and/or consumers' interests are represented on all boards and workgroups and in all policy-making activities, and participates in the selection of grantees for a consumer initiative program. For the past 13 years, DMH has set aside more than $120,000/year in grants for clients to develop and operate their own organizations, groups, and businesses, with funds coming from Central Office and several of the Areas. One recent and exemplary project funded by OCER was the writing and distribution of "Recovery Stories Written by Inspiring Young Women," edited by a

member of the Youth Development Committee who now works in the DMH Child and Adolescent Division.

The Office of Consumer and Ex-patient Relations continues to work with the state's consumer/survivor movement to further develop a statewide network and leadership academy. DMH is funding the further state-specific refinement of the leadership academy curriculum and the creation of a self-help/peer support curriculum. An application has been submitted to CMHS for a Transformation Grant, in collaboration with the University of Massachusetts, which will further enhance these initiatives and ensure that consumers are at the table at all levels of DMH. Some of the consumers involved in preparing the grant proposal included youth in transition.

A new adaptation of the leadership academy was utilized in SFY'03 to train consumers working in a DMH consumer affairs role and those serving on diverse statewide advisory committees. Experienced peer support leaders from across the state worked collaboratively to develop the draft of a training curriculum for self-help group facilitators.

SFY '05 activities will include several leadership academy trainings. Continuing education events are planned for past leadership academy graduates, including a module on legislative advocacy at the state capitol. Modules of the draft self-help curriculum will continue to be developed and field tested. The complete draft text will be completed by the end of SFY'05. The curriculum will then be used to train current and prospective group leaders in SFY '06 and SFY '07.

In April 2004, DMH issued a revised Medication Information Manual, which provides consumer and family-friendly information about commonly prescribed medications for adults and children. It is designed for clinicians to share with consumers and families when they recommend or prescribe a medication. It is also available on the DMH website for public use. DMH also issued, in February 2002, an Orientation Guide to Psychoactive Medication for Children and Adolescents, designed for parents, guardians and non-mental health specialists, and also available on the DMH website.

DMH works with Consumer Quality Initiatives (CQI), a consumer-run, non-profit organization that does consumer-to-consumer surveys. Past projects include consumer satisfaction surveys in the Western Mass. Area, to address employment needs and barriers; in the Central Mass. Area, to assess discharge planning in four intermediate care units at Worcester State Hospital; and in the Metro Boston Area, to compare rehabilitation services in two different programs. CQI also conducted interviews with case management clients at 10 sites and with patients at the DMH-operated units at Tewksbury Hospital. In addition, CQI has surveyed young adults who transitioned from child to adult services and is a key participant on the Youth Development Committee of the State Mental Health Planning Council, which is addressing services for transitional age youth. In SFY'04, CQI began the process of designing a consumer satisfaction survey as part of the Department's Psychiatric Residency and Psychology Internship Training Program (adults and children).

In addition, the Department provides funds for M*Power, an independent consumer-run organization, the Alliance for the Mentally Ill, the Parent Professional Advocacy League, the Cole Resource Center, and more than 30 clubhouses in the state.

Stigma and Discrimination

There is general agreement that consumer involvement and empowerment teach people to take control and responsibility for their lives and that this is the best way to

decrease stigma and discrimination against people with mental illness. There also is agreement that education and personal contact are two effective tools used to change attitudes.

Massachusetts is one of eight pilot states selected by SAMHSA to pilot a national anti-stigma campaign called the "Elimination of Barriers Initiative (EBI)." This campaign coincides with the release of the President's New Freedom Commission on Mental Health Final Report, *Achieving the Promise: Transforming Mental Health Care in America*, and aims to address stigma in targeted segments of the population. In addition to marketing the TV, radio and print public service announcements (PSAs) designed by the EBI consultants for the general public, DMH has chosen to focus its efforts on high school teachers and administrators, a group that was identified in national focus groups as a high profile target audience. The EBI campaign had its "kick-off" events in the summer of 2003 with the Massachusetts Secondary School Administrators Association and will be receiving and distributing program materials in SFY'05 to reach its target audiences, including a curriculum for the teachers and administrators. DMH initiated its own anti-stigma campaign in 1997, called "Changing Minds," to educate the public about mental illness. At the time, results of a statewide survey revealed that stigma would prevent most people from seeking treatment for a mental illness. Through PSAs by such notables as Tipper Gore, Mike Wallace and Leslie Stahl, plus billboard ads, brochures, a video lending library and informational forums, DMH attempted to educate both the public and policy makers about advances in research and effective treatments. The campaign also attempted to raise awareness about the discrimination experienced by people with mental illness. The EBI project will build on the successes of "Changing Minds."

Psychiatric Residency and Psychology Internship Training Program

This long-standing training program was re-procured in 2003. The contract specifications were rewritten to assure public sector clinical training experience for future mental health professionals. Through this five-year contract, DMH provides support for adult, child and forensic psychiatric residents, and psychology interns and fellows in eight accredited hospital training programs affiliated with the Harvard, Boston University and University of Massachusetts medical schools. DMH has established curriculum requirements for the trainees in such areas as cultural competence, homelessness and mental illness, co-occurring mental illness and substance abuse disorders, programs for assertive community treatment, psychosocial rehabilitation, family involvement and reducing seclusion and restraint. The new contract requires each program to provide its trainees with at least one clinical rotation in a DMH-affiliated inpatient or community program, providing a benefit for both the trainees and for DMH. DMH also encourages the programs to incorporate the use of consumers as teachers. Finally, DMH is working with Consumer Quality Initiatives, Inc. to design and conduct client satisfaction surveys for each of the training programs. As part of the evaluation process, the survey will assess the programs' aggregate understanding of the terms "recovery" and "rehabilitation."

Human Rights

DMH has two human rights directors, one for adults and one for children and adolescents. Regulation and policy call for human rights officers and human rights committees in the central office, in public and private inpatient settings and in state-operated and contracted community programs. Through its human rights function, DMH

is both a monitor and promoter of the use of the legal processes that exist pursuant to DMH regulation or sate law to protect the rights of service recipients. These include the DMH complaint process (particularly as it functions in private settings), the ISP appeal process, and the Community Residence Tenancy Law hearing process. DMH distributes a human rights handbook and human rights brochure for parents and children, and has created a human rights video for children and adolescents. For years, DMH sponsored two human rights conferences a year, each of which used to attract more than *800* participants, including clients, advocates, DMH and provider clinical and administrative staff, family members and other interested citizens. Budget reductions have necessitated the temporary cancellation of these as well as other DMH-sponsored clinical conferences. In SFY'03, after a lengthy process that involved many stakeholders, DMH issued a revised human rights policy. The human rights handbook is being revised and will be issued in SFY'05 as a companion to this policy.

Multicultural Affairs

The DMH Office of Multicultural Affairs (OMCA) oversees various activities, such as interpreter and translation services, refugee assistance, cultural competence training, program development, networking, research, and staff recruitment and development. A Multicultural Mental Health Research and Cultural Competency Network Directory as well as translations of the DMH service applications, Medication Information Manual, human rights postings and forms used by clients, families and guardians in Spanish, Russian, Haitian Creole, Portuguese, Chinese and Khmer are available through the office.

DMH continues to support statewide and Area-based activities that involve outreach to minority communities. The OMCA will continue to implement the Governor's Diversity Initiative, and its statewide Cultural Competence Action Team is in the process of developing and implementing its second three-year Cultural Competence Action Plan (SFY'05-'07). In addition, each Area has a multicultural committee and/or diversity team. For example, on the statewide level in SFY'04, as part of the Massachusetts Initiative of Multicultural Community Outreach, DMH collaborated with the Massachusetts Office for Refugees and Immigrants in a program to reach out to and promote mental health in diverse racial, ethnic and minority communities. A program that began with four providers, the Haitian American Public Health Initiative, International Institute of Boston, Boston Health Care/Islamic Society of Boston, and Child and Family Services of the Pioneer Valley, eventually was extended to the Asian community, Black Ministerial Alliance, Latino Mental Health Collaborative and the Harvard Program in Refugee Trauma. In all, about 25 community forums were held and more than 90 primary care practitioners were trained.

Other principal activities planned for the next three years include improving data integrity (e.g., race and ethnicity), matching demographic census data with staff demographics and program development; analyzing the procurement process for all EOHHS agencies to increase access for multicultural and multilingual populations; and implementing a new grant called "*Cuerpo Sano, Mente Sana/Healthy Body, Healthy Mind.*" This grant will provide training, education and outreach for health and human service providers, consumers and their families in the Latino community in Worcester. The project, funded by Blue Cross/Blue Shield Foundation of Massachusetts, is aimed at reducing stigma, increasing health literacy, empowering consumers and families, and promoting cultural competence based on previous findings of the needs assessment.

Office of Investigations

The Office of Investigations (OI) is charged under DMH regulations with conducting investigations into complaints alleging illegal, dangerous or inhumane conditions or events, both in inpatient and community settings, for adults and children. In addition, OI collects data on critical incidents and client deaths, reported by the Areas pursuant to a Critical Incident Reporting Protocol. The protocol has been revised to ensure consistency with other reporting requirements (e.g., ORYX), as well as DMH policy and regulation. The protocol clarifies which incidents are reportable and which adults, children and adolescents are subject to its provisions. Implementing corrective measures and ensuring integration of these improvements as quality measures across the system of care is a priority of DMH.

Services for Clients with Special Needs

Clients with special needs receive care in the community. Planning and program development for these clients often take place at a variety of levels, however, due either to low incidence or the need for specialized services (e.g., deaf, brain-injured).

Deaf, Hard of Hearing and Late-deafened

DMH continues to work with the Massachusetts Commission for the Deaf and Hard of Hearing concerning referrals, eligibility determination and communication access. Whenever indicated, every attempt is made to have client assessments conducted by evaluators trained to communicate in American Sign Language (ASL). DMH operates an inpatient unit for deaf, hard of hearing and late-deafened patients that serves the entire state, and accepts adolescents and adults. In SFY'03, at the Center for Public Representation's request, DMH conducted a survey to document the prevalence, demographics, clinical profile, needs and treatment services available for *152* deaf, hard of hearing and late-deafened DMH clients (including adults and children) to determine the frequency and intensity of their unmet needs. DMH case managers carried out the survey and *29* of the clients were interviewed by Area Medical Directors to corroborate the case managers' findings. As a result of the survey, DMH has identified and reassigned a social worker, fluent in ASL and culturally competent in deafness, to provide clinical oversight and consultation to the DMH field. In addition, one existing and three new case manager positions will be filled by individuals who are deaf, fluent in sign language and knowledgeable about deaf culture. Area and Site staff have been trained to use TTY machines, which are operating in each Area and Site office, telephone relay instructions have been publicized in the Resource Guide and on the Department's two websites, and trainings on Culturally Competent Mental Health Services for Deaf and Hard of Hearing Individuals are scheduled, beginning in September 2004. Four new residential slots have been added and a coordinator-educator-outreach position has been funded in the Central Mass. Area. When resources become available, other community services will be added or expanded to serve this population.

Co-occurring Mental Illness and Substance Abuse

DMH is committed to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. In SFY'00, the application for adults, children and adolescents seeking DMH continuing care community services was revised to ensure that individuals

with a dual diagnosis are not excluded from DMH services because of the difficulty in determining which diagnosis is the primary one. The DPH Bureau of Substance Abuse Services designed a substance use screening tool and inventory now used for all applicants for DMH services. DMH also incorporated program standards for the care and treatment of individuals with co-occurring disorders into its Residential Services contracts. All residential providers are now required to meet these standards. In addition, training requirements for managing individuals with co-occurring disorders were included in the Department's SFY'04 Psychiatry Residency and Psychology Internship Training Program, which is being implemented now.

Other ongoing collaborative efforts between DMH, DPH, DMA and MBHP (DMA's behavioral health managed care vendor) include a statewide Interagency Work Group on Dual Diagnosis. This group meets to present and discuss issues of interest to members, including providing training support for interagency collaboration. The two agencies also provide matching funds for cross training of DMH and DPH staff in dual diagnosis in the DMH North East Area.

Finally, DMH worked with DMA to include two primary performance standards emphasizing dual diagnosis services in DMA's contract with MBHP. One performance standard will lead to the establishment of additional consumer facilitated Dual Recovery Anonymous 12-step recovery groups in the Commonwealth. The other requires MBHP to work with DMH and DPH to develop treatment improvement initiatives for adults and adolescents with co-occurring disorders that are based upon the Community Consensus-Building Collaborative Principles adopted by DMH as the result of a multi-year SAMHSA grant. The DMH Commissioner plans to revisit and update the "Principles" this year and is in the process of setting goals to improve integrated treatment options for individuals with co-occurring disorders.

Parents with Mental Illness

The Family Project and the Parenting Options Project address the special parenting needs and challenges of adults with mental illness and their children, issues that are often overlooked in traditional treatment settings. Both projects are carried out through collaboration between clinicians and academic researchers at UMass Medical School and a group of DMH-funded clubhouses. Continued funding for the Parenting Options Project from the Massachusetts Bar Foundation, Mental Health Legal Advisors Committee and DMH (block grant) enables staff to continue providing legal assistance to parents, primarily in clubhouses, around issues concerning child custody and visitation, and supports the development of protocols for other attorneys to use to help parents with mental illness.

In developing Individual Service Plans (ISP), DMH has begun to discuss how the needs of the entire family, in addition to the needs of the identified client, should be referenced within the ISP. This affirms the increasing recognition of the importance of family in assessing the needs of and planning services for adults.

DMH also is working with DSS to design training for DSS staff about identifying and working with parents who have mental illness. DMH now makes short-term services available to parents involved with DSS who are applying for adult DMH services. Finally, DPH, which oversees Early Intervention Services, will identify parents with mental illness among its EI clientele.

Access to Primary Health Care

There are several ways in which DMH intends to increase the likelihood that clients have access to primary health care. One of the requirements included in the annual review of each client's Individual Service Plan, as per the Service Planning regulations, is evidence of an annual physical and dental exam. DMH also tracks whether adult clients in residential programs see their primary care physician annually. DMH and DMA continue their commitment to supporting case managers' direct contact with DMH clients' primary care clinicians to ascertain whether clients are linked with this important resource.

Service Issues and Gaps Relating to Adults, Children and Adolescents

Although clients who are determined eligible for DMH community services usually receive at least one service, DMH is still unable to provide case management and residential services to all of the clients who are eligible for and want them. It is also striving to fulfill its commitment to provide integrated services to those with co-occurring mental health and substance disorders. The hospital closures have provided the best opportunities for reallocating resources from inpatient to community care, thus improving this picture, but gaps remain. In addition, DMH is working actively with consumer and family groups to strengthen their voice in policy and planning and to reinvigorate the focus on recovery. Various consumer groups, including the Youth Development Committee, the DMH Office of Consumer and Ex-Patient Relations, University of Massachusetts and other DMH staff are collaboratively exploring ways to enhance this process and have applied jointly for a SAMHSA Transformation grant to be used exclusively for this purpose. Planned expansion of peer support activities also will propel this agenda forward.

Of significant concern to advocates and DMH is the legislative decision to discontinue vision and dental benefits to adult Medicaid recipients in response to budget pressures. The implications for DMH clients are profound, potentially affecting general health, safety, employment and social interaction. Although the dental benefit was retained for children, access to care is extremely limited due to dentists' unwillingness to accept Medicaid's fees or submit to their reimbursement process. The latter is being addressed by recently passed legislation.

DMH continues to refine and expand the number and array of appropriate and necessary community-based services to meet the needs of its clients. It is committed to ensuring that individuals who need treatment get the appropriate services they need and that families get needed supports, through insurance if available, or through the public sector. For youth, the difficulty in access to community-based services has been highlighted for the past few years as the so-called "stuck kid" problem, children remaining in hospitals after clinically ready for discharge. DMH has been working with DSS, DMA and advocacy groups to try to resolve this problem, and in the process, the agencies have come to realize that numerous structural factors contribute to the problem. The need for both short-term interventions and a long-term strategic plan to effect significant change, including expansion of community services that may prevent the need for hospitalization and residential treatment, has been acknowledged. A focus on stuck kids and service access issues has been maintained through the activities of the Children's Mental Health Commission, a legislatively-created group established to collect data about availability and utilization of mental health services for children. The Commission has

expanded its scope beyond the initial data mandate and is working to design a statewide system of care that can provide appropriate services in the least restrictive setting to all children and adolescents. The Commission includes key state agencies, advocates and providers.

Criterion I: Issues Pertinent to Adults

Access to and Availability of Services

DMH provides a range of continuing care community services for adults. These include PACT teams, residential services (including supported housing), case management, respite, day treatment, supported employment, supported education, peer support, outpatient, day activity programs, medication monitoring, psychosocial rehabilitation programs (including clubhouses), family support, and client empowerment activities. In addition, DMH continues to provide all extended stay inpatient services, as well as acute inpatient and emergency services in a small number of state-operated programs. However, most of the individuals who were formerly served in DMH-contracted acute and emergency programs are now served in programs managed by MBHP, DMA's contracted behavioral health vendor.

Each of the six DMH Areas assesses its needs, and develops and manages its programs, mostly through contracts with local providers. Each Area also manages any state psychiatric hospital or CMHC located within its geographic domain. Only forensic mental health services are managed centrally, although forensic staff are situated in the Areas and forensic services are delivered in the state facilities, court clinics and through various county jails and correctional facilities.

A principal measure of accessibility is the ease with which individuals are able to apply for services and the length of time they must wait before those services are available. In that spirit, DMH is tracking its success in this arena, documenting the wait time between application and start of services. A brochure for individuals and families that provides "how to" application guidance has been developed and distributed.

Reducing the Rate of Hospitalization

During SFY'03, DMH closed Medfield State Hospital (census = 147 in 2001), as well as a 20-bed unit at Worcester State Hospital and a 36-bed unit at Tewksbury Hospital (a DPH/DMH facility). After a lengthy process to assess the readiness of each patient for community placement, patients were either moved into supported community living arrangements or to another DMH or DMH/DPH hospital. Overall inpatient capacity was reduced from 1,127 to 948, a net reduction of 179 beds. A significant portion of the savings (in operating funds) derived from closing Medfield was used to expand the community service system. This expansion also helped DMH meet the requirements of the U.S. Supreme Court' s Olmstead decision.

- *$10.2 million* was used to develop *255* community placements for patients residing in DMH facilities, including *59* residents from Medfield State Hospital and *60* residents from Westborough State Hospital. The rest came from other Areas in the state.
- *$6.7 million* was used to increase the number of DMH-funded PACT teams from five to 13. The teams are currently serving about *600* DMH clients.

- The remaining *$4.6 million* was reallocated to create two new adult inpatient units for Medfield patients needing ongoing inpatient care.

Health and Wellness

In October 2002, DMH issued its second "Mortality Report" and is currently preparing to release a third one. These reports continue to draw attention to the fact that adults with serious mental illness are more likely to die from cardiac, respiratory and other medical diseases than their counterparts of the same age without mental illness in the Commonwealth and in the United States. The report has strengthened the DMH Commissioner's commitment to invest in health and wellness initiatives for DMH clients and to ensure that clients are connected appropriately to the general medical and dental communities. Some of these initiatives are improving access to primary care, reducing smoking, and providing nutrition information and exercise opportunities. DMH also is actively tracking the incidence of Hepatitis C in its inpatient population, after a sampling of adult patients revealed that about 10% were infected, a rate five to eight times higher than the general population. As a result, DMH developed a protocol to test, track and treat adult patients already in the hospital and to refer them for appropriate treatment upon discharge.

DMH has undertaken several measures to address the fact that DMH clients and people with serious mental illness in general, lack access to primary health care, and/or have undiagnosed or untreated physical illnesses. DMH is actively working with the Department of Public Health (DPH) to bring to DMH clients DPH programs targeting obesity, physical inactivity, smoking and cardiovascular risk reduction. DMH remains committed to addressing these long neglected aspects of psychiatric treatment, which underscore the essential importance of the brain/body connection**.** DMH is an active member of the statewide Cardiovascular Health Coalition, which is in the process of developing a number of statewide initiatives to reduce cardiovascular risk, especially in populations with healthcare disparities and high prevalence of cardiac mortality. DMH also participates in the Massachusetts Coalition to Reduce Medical Error. As part of the DMH commitment to improve patient safety, data have now been obtained from Medicaid that will permit a survey among DMH clients of potentially adverse drug interactions, as well as utilization of screening procedures and access to therapeutic cardiac interventions. DMH is also working with the Bureau of Statistics at DPH to reassess Behavioral Risk Factor Survey data in order to quantify health risks in persons who self identify as having depression or other mental illness.

DMH continues to fund a research project to help DMH clients in the community with schizophrenia, schizoaffective disorder and bipolar disorder reduce or stop smoking. This voluntary program is in its fourth year and will be expanded to examine the reasons for relapse as well.

Peer Supports

In SFY'99, DMH created a new program code called "peer support" to formalize and legitimize the purchase of activities such as "warm lines," client-to-client education, buddy programs, etc. in a public mental health system. The Department identified activities and/or standards for such a program, and solicited bids for these services. The activities have steadily expanded and now include a program of peer education, support and advocacy in DMH facilities statewide to help prepare clients for community integration. Peer support activities were expanded in SFY'02, with the additional block

grant funds available to DMH, to reach further into the community, and there is discussion about expanding it further by introducing a training and certification program.

Clinical Practice Guidelines

In order to ensure the highest quality of care for DMH clients, clinical practice guidelines have been developed and issued by DMH for schizophrenia and bipolar disorder, with "user-friendly" versions for families and consumers. These guidelines were developed jointly by DMH, DMA, MBHP, and the health maintenance organizations in the state to ensure standardization across sites where DMH clients may receive care. The guidelines have been distributed widely in the field under the direction of the Area Medical Directors.

Elders

Over the last several years, DMH has steadily increased its focus on the special needs of elderly people with mental illness. Four block grant funded training conferences a year, organized by the Massachusetts Association of Older Americans (MAOA), are conducted for DMH and provider staff, clients, home care agencies and Councils on Aging. These sessions raise awareness concerning the special mental health needs of the elderly and focus on diagnosis, medication interactions, depression, growth and development, substance abuse, etc. They continue to be enthusiastically received and are usually attended by *100-150* people.

DMH continues to work collaboratively with the MAOA on a study proposal funded by the Medical Foundation, as administrator for the Charles H. Farnsworth Charitable Trust, entitled *Access to Mental Health Treatment for Elders Living in the Community: Perceived Outcomes of Requests for Services.* The study will focus on outcomes of referrals for mental health services as perceived by elders, their family caregivers, aging network staff, and primary care physicians. The study is designed to obtain information about systemic barriers to care as perceived by members of the focus groups. In working with the MAOA on this project, a DMH representative will participate on an expert advisory panel, provide consultation on DMH intake/outreach policy and standards, and participate in an analysis of the final report. MAOA also is sponsoring an open forum in September 2004, called “Elder Issues in the Commonwealth: Identifying Issues, Speaking Our Minds,” which will provide another opportunity to articulate challenges to providing for the mental health needs of this population.

In addition, DMH is participating on a panel overseeing a study by the Gerontology Unit at UMass/Boston. A survey has been conducted of elders to determine their knowledge of mental health benefits afforded by Medicaid and other supplemental insurance providers. Elders also will be asked about their use of and attitudes about mental health services and benefits. The results are expected to become available sometime in the early fall.

Finally, DMH, the Boston Department of Elder Affairs, the Boston Housing Authority, and an elder advocacy organization have developed a training module for janitors, security guards, facility service workers, et al. who work in public elderly housing developments to identify elders with mental health/substance abuse problems. The training serves two purposes: to help these workers, who have significant contact with elderly residents, to recognize/identify tenants who might be having mental health problems; and to bring these tenants to the attention of appropriate housing authority staff so that referrals and interventions can be made. DMH employees are involved in training

housing authority staff. The intent of the program is to get more elderly people with mental illness in treatment and reduce the fear and stigma around residents with mental illness. This initiative also includes a lot of younger adults with mental illness living in elderly housing.

Elder advocates have raised concerns about the lack of 24-hour access to specialists in geriatric medicine and specialized training for emergency staff on elder mental health needs in some of the emergency services programs. DMH will try to address this problem when the emergency programs are re-procured next year by requiring the emergency services contractor to include and monitor this availability. DMH is continuing in its efforts with primary care physicians to raise awareness about elders who need but do not seek mental health services, and continues to collaborate with the Executive Office of Elder Affairs (EOEA). A project is under way involving DMH, advocates and the EOEA to develop and implement, over the next three years, a state mental health plan for elders.

One of the new groups to partner with DMH is the "The Mental and Cognitive Health Committee of the Boston Partnership for Older Adults (BPOA) - the Boston Chapter of the MA Aging and Mental Health Coalition. The BPOA is one of eight locations nationally selected by the Robert Wood Johnson Foundation to address critical issues impacting the service delivery systems supporting the needs of the country's aging population. The purpose of the BPOA Mental and Cognitive Health Committee is to increase awareness and reduce the negative impact of mental and cognitive health issues on older adults, care partners and the larger community. The group's goal is to shape an effective mental and cognitive health system for Boston elders across the entire continuum of care. A position paper being prepared will attempt to define the scope and nature of elder mental and cognitive health issues, as well as further describe the impact and cost of these issues to the overall system, to older adults and to their family caregivers. The paper will conclude with an analysis of existing resources and recommendations for systemic improvements."

Forensic Mental Health Services

DMH has a long history of providing forensic mental health services within its facilities and to the criminal justice system. DMH provides mental health consultation and evaluation services to the criminal courts, as well as services to individuals with mental illness in ***state*** correctional facilities, although formal forensic consultation services to ***county*** correctional facilities were eliminated in the SFY'03 budget. If requested to do so, DMH facilitates post-mortem peer reviews with Department of Correction staff after a suicide or other adverse event in its system. DMH forensic specialists perform evaluations in on-site court clinics on an as-needed basis.

DMH has a Forensic Transition Team program to assist DMH-eligible adult inmates being released from county houses of correction or state prisons and DMH-eligible young adults who are being released from DYS custody. Services are coordinated during the transition from incarceration to the community. Coordinators work with Area-based care managers to provide continuity of care for the offender through early engagement, consistent support and a well-monitored transition to community care. As a result, recidivism among these populations has been reduced.

In accordance with MGL c. 127 §39, DMH coordinates a multidisciplinary team that visits segregated units (i.e., separated from the mainstream prison population) at each

state prison on a regular basis to ensure that inmates in those units are receiving appropriate medical, dental and psychiatric care.

Planning has begun on several initiatives to be undertaken over the next several years. These include: developing urgent care behavioral health services to support successful community re-entry; developing policies and protocols to standardize community placements of registered sex offenders with serious mental illness; developing a plan, in collaboration with Medicaid, to have health insurance immediately available for Medicaid-eligible inmates being released to the community; increasing utilization of diversionary levels of care in court clinics; enhancing coordination of services between court clinics and emergency service programs; and expanding jail diversion programs. As these projects begin to take shape, performance measures and indicators will be developed and added to the Plan.

CRITERION I - ADULT PERFORMANCE INDICATORS

Goal I/1 A: The Department addresses the mental health needs of people in the Commonwealth.

Population: **Adults with mental illness**

Objective I/1 A: **Prepare for coordinating and delivering mental health services in the event and/or aftermath of a natural or man-made disaster.**

Brief Name: *Disaster Management*

Indicator: DMH collaborates with its community partners to foster resilience and preparedness, and increase stress management skills among the population before any untoward event.

Measure: The Commonwealth prepares for and responds to the mental health needs of its citizens in the event of a disaster.

Year 1: Develop an evidence-based, culturally competent and developmentally appropriate program to train licensed mental health professionals to respond appropriately and quickly in the event of a natural and/or man-made disaster; train 75 crisis counselors.

Year 2: Continue to train 75 crisis counselors per quarter; develop official credentialing criteria for crisis counselors and integrate their certification with certification criteria being developed by DPH for health care volunteers.

Year 3: Continue to train 75 crisis counselors per quarter; identify trained DMH crisis counselors in each DMH Area to function as liaisons with regional DPH and Department of Homeland Security planning groups to ensure that behavioral health issues are included in all aspects of disaster planning and management.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/1. *Disaster Management*					
Value/Measure: Massachusetts prepares for and responds to the mental health needs of its citizens in the event of a disaster	Post-9/11 counseling provided	DPH grant received; DMH role defined	Training curriculum designed; 75 clinicians trained	Credential process designed; 75 clinicians/ Q trained	DMH-DPH-DHS liaison created; 75 clinicians/ Q trained

Data Source: DMH/DPH Grants Management

Background: While the primary mission of the Massachusetts Department of Mental Health is to provide services to citizens with long-term or serious mental illness, the Massachusetts statute governing DMH also requires it to *take cognizance of all matters*

affecting the mental health needs of the citizens of the Commonwealth. Accordingly, DMH has structures in place to provide crisis counseling to the general public during times of local or large-scale catastrophic events. For ten years, DMH has had a Director of Emergency Management at its Central Office, Disaster Coordinators in each of its six Areas and a call-up roster of several hundred, trained crisis counselors available for deployment. These services, which DMH provides free of charge, consist of acute crisis counseling in the immediate aftermath of an event, accessed via 24/7 DMH Emergency Management contact numbers.

As the state mental health authority, DMH applies for and administers federal disaster mental health grants, most notably the FEMA Crisis Counseling grant in the event of a Presidential Declaration of Disaster. Massachusetts, as one of the states directly affected by September 11, 2001, obtained a FEMA grant to create the MASS Counseling Network Program which provided individual and group counseling and educational presentations for over 80,000 citizens of Massachusetts.

DMH has a multi-year history of shared programs with the Massachusetts Department of Public Health (DPH) and the two departments have shared SAMHSA grant money to enhance all-hazards disaster planning for DMH and the DPH Bureau of Substance Abuse Programs. In 2003, with federal grant guidance mandating inclusion of behavioral health issues in public health disaster preparedness activities, DPH provided DMH with $450,000 from its HRSA grant for disaster preparedness. DMH now has a Clinical Director for disaster behavioral health who is working with the DPH Emergency Cluster on including psychosocial issues in workgroups on workforce development, surge capacity, risk communication, drills and exercises, and education/training. DMH has just awarded a contract for a Crisis Counselor Training Program which will train and credential a new group of clinicians to conduct evidence-informed, culturally competent, developmentally appropriate counseling in the immediate aftermath of disaster. DMH and DPH together are developing a menu of trainings in psychosocial issues specific to a variety of audiences, including primary care providers, emergency room personnel, public health staff and public safety officials.

Significance: The Department's enabling statute requires DMH to take cognizance of the mental health needs of the citizens of the Commonwealth.

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Objective I/1/2 A: **Continue efforts to reduce the stigma associated with mental illness**

Brief Name: *Reducing stigma*

Indicator: The Elimination of Barriers Initiative targeted to the general public is implemented through placement of television and radio Public Service Announcements and print articles.

Measure: Public information campaign reduces the stigma associated with mental illness

Year 1: Place and track SAMHSA-supported Public Service Announcements for TV, radio and print media in local and statewide media outlets.

Year 2: Place and track SAMHSA-supported Public Service Announcements for TV, radio and print media in local and statewide media outlets.

Year 3: Evaluate public attitudes to determine whether attitudes have shifted and stigma has decreased.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/2. *Reducing Stigma*					
Value: Stigma associated with seeking help for mental illness is decreased		Compared to 1997, stigma is decreased			Compared to SFY'04, stigma is decreased
Measure: PSAs and articles are placed (Years 1 & 2); stigma is decreased (Year 3).	Mass. selected for EBI	Public opinion survey conducted by MAMH	3 TV, 3 radio, 5 cable, 5 print ads & 2 articles placed	3 TV, 3 radio, 5 cable, 5 print ads & 2 articles placed	Post-EBI evaluation conducted

Data Source: DMH Office of Policy Development; Mass. Association for Mental Health (MAMH)

Background: DMH launched a successful statewide anti-stigma campaign in 1997. A survey this past year, commissioned by MAMH, demonstrated that public attitudes have changed since that time and that people are more willing to seek help for emotional problems. There is still a long way to go, however. In 2003, Massachusetts was selected by SAMHSA as one of eight states to pilot its new anti-stigma campaign called, the "Elimination of Barriers Initiative (EBI)." After much preparatory work, the materials being developed for this campaign are expected in SFY'05 and will include PSAs for TV and radio as well as print ads and drop-in articles targeted to the general population. As PSAs and ads are placed, viewers and listeners will be directed to call a national hotline, which will then direct Massachusetts callers to DMH, MAMH or several other consumer and family organizations for more information, including a bilingual line at DMH. DMH and MAMH will track these calls to gauge the success of the placements. A more specific campaign, targeted at high school teachers and administrators, is being launched also (see C/A Plan for description). DMH has partnered with the Massachusetts Association for Mental Health in this effort. Part of the EBI support includes pre and post-EBI evaluation surveys conducted by a national organization.

Significance: Decreasing stigma promotes increased utilization of mental health services.
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Goal I/2 A: DMH clients receive coordinated and integrated services.

Population: **Adults with serious mental illness**

Objective I/2/1 A: **Provide case management services to eligible adult clients**

Brief Name: *Case Management*

Indicator: the percent of adults receiving case management services

Measure: # of adults receiving case management services
# of eligible adult clients

Year 1: Maintain case management services for adults

Year 2: Maintain case management services for adults

Year 3: Maintain case management services for adults

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/2/1. *Case Management*					
Value: the % of adults receiving case management services	**50.9%**	**56.3%**	**56%**	**56%**	**56%**
Numerator: # of adults receiving case management services	**10,688**	**10,789**			
Denominator: # of eligible adult clients (*does not include 650 PACT team clients)	**20,992**	**19,156***			

Data Source: DMH Data Warehouse
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Objective I/2/2 A: **Survey adults receiving case management services to determine if they perceive case management services positively.**

Brief Name: *Case management effectiveness*

Indicator: the percent of case managed adults who perceive case management services positively

Measure: # of case managed adults surveyed, who perceive case management services positively
# of case managed adults surveyed

Year 1: Planning year for developing a consumer satisfaction survey

Year 2: *75%* of adult clients surveyed perceive case management positively

Year 3: *80%* of adult clients surveyed perceive case management positively

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/2/2. *Case management effectiveness*					
Value: the % of case managed adults who perceive case management positively	**79%**	**N/A**	**Plan survey**	**75%**	**80%**
Numerator: # of case managed adults surveyed, who perceive case management positively	**201**	**N/A**			
Denominator: # of adults receiving case management services surveyed	**254**	**N/A**			

Data Source: Consumer Quality Initiatives, Inc.; DMH Div. of Mental Health Services
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Objective I/2/3 A: **Maintain PACT team clients successfully in the community.**

Brief Name: *PACT team services*

Indicator: the percent of adults served by a PACT team who remained in the community (i.e., out of state hospital)

Measures: # of adults served by a PACT team who remain in the community/in housing/receive substance abuse treatment
# of adults served by a PACT team

Year 1: *93%* of adults served by a PACT team remain out of the (state) hospital; *75%* remain in housing; *90%* receive substance abuse treatment

Year 2: *93%* of adults served by a PACT team remain out of the (state) hospital; *80%* remain in housing; *90%* receive substance abuse treatment

Year 3: 93% of adults served by a PACT team remain out of the (state) hospital; *80%* remain in housing; *90%* receive substance abuse treatment

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/2/3. *PACT team services*					
Value: the % of adults served by a PACT team who remain out of state hospital: remain housed: receive S/A treatment:	**N/A** **81.3%** **84.8%** (8 of 8 programs)	**93.4%** **57%** **95.3%** (5 of 13 programs)	**93%** **75%** **90%**	**93%** **80%** **90%**	**93%** **80%** **90%**
Numerator: # of adults served by a PACT team who remain out of state hospital: remain housed: receive S/A treatment:	**N/A** **265/326** **140/165**	**607/650** **147/258** **122/128**			
Denominator: total # of adults served by PACT teams	**540**	**650**			

Data Source: DMH Data Warehouse/Performance Based Contracting

Background: DMH has made every effort to retain a stable number of case managers and is committed to at least maintaining case management services at the SFY'04 level. By conducting a consumer satisfaction survey, DMH will gauge the effectiveness of these sought after services, as perceived by clients.

For those clients in the community whose multiple problems, including homelessness and non-compliance, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and keeping them out of the hospital, DMH, with DMA assistance, has created several PACT teams. There are currently 13 teams in place, statewide, including eight new teams funded with savings derived from closing Medfield State Hospital. Since recipients of PACT services receive intensive care coordination from the team, these clients do not receive DMH case management services and are not included in the numerator or denominator in Objective I/2/2 (case management).

Special Issues: Additional funding is necessary to increase the number of case managers and PACT teams.

Significance: Case management and PACT team services provide the integration and coordination necessary to support clients' ability to live independently in the community and reduce the need for hospitalization.

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Goal I/3 A: DMH clients maintain healthy lifestyles.

Objective I/3/1 A: **Ensure that clients in DMH residential programs are seen by a primary care clinician at least once per year.**

Brief Name: *Primary medical care*

Indicator: the percent of adults in DMH residential programs who are seen by a primary care clinician at least once per year

Measure: # of adults who see a primary care clinician
# of adults in DMH residential programs

Year 1: Maintain or increase the number of adults who see their primary care clinician

Year 2: Maintain or increase the number of adults who see their primary care clinician

Year 3: Maintain or increase the number of adults who see their primary care clinician

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/3/1. *Primary medical care*					
Value: the % of adults in DMH residential programs who receive primary health care	**80%**	**83.8%**	**85%**	**88%**	**90%**
Numerator: # of adults in DMH residential programs who see a primary care clinician annually	**5,645**	**6,090**			
Denominator: # of adults in DMH residential programs	**7,240**	**7,267**			

Data Source: Performance Based Contracting Database

Background: In SFY'03 and '04, there were an additional 8.7% and 8.6% of clients, respectively, who refused to see a primary care clinician. The program goal is to work with these clients to encourage them to see a primary care clinician.

++

Objective I/3/2 A: Reduce smoking among a group of community clients.

Population: Adults with serious mental illness

Brief Name: *Smoking Cessation and Reduction*

Indicator: the percent of DMH clients in a pilot program who voluntarily stop or reduce smoking

Measure (a): # of adults who stop smoking in bupropion or NRT program
# of adults who participate in the program

Measure (b): # of adults who do not relapse in NRT and/or CBT program
# of adults who participate in the program

Year 1: (a) In smoking cessation program *35%* will cease smoking during treatment and *15%* will remain abstinent six months following end of treatment;
(b) In relapse prevention program *30%* of those initially abstinent will remain abstinent for six months with six months CBT and *50%* will remain abstinent on six months of NRT +CBT.

Year 2: (a) In smoking cessation program *35%* will cease smoking during treatment and *15%* will remain abstinent six months following end of treatment;
(b) In relapse prevention program *30%* of those initially abstinent will remain abstinent for six months with six months CBT and *50%* will remain abstinent on six months of NRT +CBT.

Year 1: (a) In smoking cessation program *35%* will cease smoking during treatment and *15%* will remain abstinent six months following end of treatment;
(b) In relapse prevention program *30%* of those initially abstinent will remain abstinent for six months with six months CBT and *50%* will remain abstinent on six months of NRT +CBT.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/3/2. *Smoking Cessation and Reduction*					
Value: the % of DMH clients in a pilot program who (a) voluntarily stop smoking (b) remain abstinent	**30% after 12-week program; 45% overall**		**35%/15%** **30%/50%**	**35%/15%** **30%/50%**	**35%/15%** **30%/50%**
Numerator: # of adults who stop smoking or remain abstinent (a): voluntarily stop smoking (b): remain abstinent			**14/6** **9/15**	**14/6** **18/30**	**14/6** **18/30**
Denominator: # of adults who participate in the program (a): voluntarily stop smoking (b): remain abstinent	**46**		**40** **30**	**40** **60**	**40** **60**

Data Source: Independent Research Project

Background: People with serious mental illness smoke at significantly higher rates than people in the general population. Successive DMH Mortality Reports, based on a review of DMH client deaths, have revealed that significantly more people with serious mental illness die from cardiovascular and respiratory illness than people of the same age in the general population. Cigarette smoking is an important causal factor for this premature mortality for patients with major mental illness, and successful smoking cessation programs could significantly reduce this burden. The goal of smoking cessation in this population is complicated by the fact that nicotine may provide clinical benefit and smoking cessation may have transient or lasting negative clinical consequences for people with some mental illnesses. Therefore, clinicians have proceeded cautiously. Block grant funds will enable a DMH-affiliated psychiatrist to conduct a well-controlled and carefully supervised smoking cessation treatment program as well as a relapse prevention study for adults with serious mental illness living in the community, over three years.

Clients from various outpatient settings around the state who volunteer for this program will receive a variety of interventions that may work to prevent or reduce negative clinical consequences of smoking cessation and improve smoking cessation rates and continued abstinence in this population. All participants will receive careful clinical monitoring. Many levels of clinical support are built into the program, and separate research grant funding will be used to document the outcome in terms of smoking cessation and stability of clinical symptoms.

The plan is to enroll 120 subjects (40 per year) into smoking cessation programs. Some will be enrolled into programs with open label bupropion or nicotine replacement therapy (NRT) treatment. Some will be enrolled into trials comparing new treatments or treatment administration schedules with control treatments. The researcher projects a 35% cessation rate during treatment and a 15% cessation rate six months following discontinuation of treatment.

The relapse rate is 62-80% in six months following treatment discontinuation. During the three-year period, in addition to enrolling smokers with schizophrenia, schizoaffective disorder and bipolar disorder in the smoking cessation programs, the researchers also will begin an initiative to reduce the relapse rate. They will begin with 30 subjects who have been abstinent for less than six months. This program will initially employ cognitive behavioral therapy (CBT) only. In the second and third years of the study, they will conduct a trial of long-term NRT and CBT vs. CBT alone for relapse prevention in clients who have been abstinent for four weeks. They will enroll 60 subjects in this trial. They anticipate a 70% relapse rate on CBT alone and a 50% relapse rate on NRT+CBT at six months following discontinuation of treatment.

Significance: Promoting client wellness is a major goal of DMH; maintaining a healthy lifestyle improves quality of life and increases longevity.
++

Goal I/4 A: Adults with serious mental illness achieve maximum independence and highest functioning.

Population: **Adults with serious mental illness**

Objective I/4/1 A: **Increase the number of adults living independently in the community with residential support services.**

Brief Name: *Community Residential Services*

Indicator: **the percent of DMH clients living independently with clinical and residential support services**

Measure: # of adults receiving residential support services / # of adults eligible to receive residential support services

Year 1: *68%* of eligible clients (requesting residential services) receive residential services

Year 2: *68%* of eligible clients (requesting residential services) receive residential services

Year 3: *68%* of eligible clients (requesting residential services) receive residential services

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/1. *Community residential services*					
Value: the % of DMH clients living independently with residential support services	**71%**	**68.1%**	**68%**	**68%**	**68%**
Numerator: # of adults receiving residential support services	**8,429**	**7,267**			
Denominator: # of adults eligible to receive residential support services	**11,829**	**10,667**			

Data Source: DMH Data Warehouse

Background: The numerator represents an unduplicated number of individuals receiving residential services (both contracted and state-run). The denominator represents those consumers who have requested and are eligible for residential services. Although the SFY'03 and SFY'04 budgets sustained significant cuts, DMH made every effort to protect its residential capacity. The increases in capacity in SFY'03 and SFY'04 (over previous years) were due to several factors. The legislature created a separate appropriation in SFY'03 ($3.6 million) for community residential placements for clients leaving Medfield State Hospital as it closed down. Savings from the closure were used to annualize

support in SFY'04 and beyond for these new residential placements and for the new PACT teams.

Significance: Increasing independence and functioning for people with serious mental illness is a primary goal of DMH.
++

Objective I/4/2-A: Assist adults in obtaining employment.

Brief Name: *Employment*

Indicator: the percent of adults in DMH-sponsored employment programs placed in jobs

Measure: # of adults from DMH-sponsored employment programs employed
# of adults participating in DMH-sponsored employment programs (SEE & Clubhouse)

Year 1: *56%* (SEE) and *48%* (Clubhouse) of adults participating in DMH-sponsored employment programs are placed in jobs outside the program

Year 2: *56%* (SEE) and *48%* (Clubhouse) of adults participating in DMH-sponsored employment programs are placed in jobs outside the program

Year 3: *56%* (SEE) and *48%* (Clubhouse) of adults participating in DMH-sponsored employment programs are placed in jobs outside the program

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/2. *Employment*					
Value: the % of adults in DMH-sponsored employment programs placed in jobs SEE: Clubhouse:	**56.2%** **48.1%**	**56.8%** **48.8%**	**56%** **48%**	**56%** **48%**	**56%** **48%**
Numerator: # of adults employed from SEE: Clubhouse: employment programs	**1,380** **2,605**	**1,402** **2,627**			
Denominator: # of adults participating in employment programs. SEE: Clubhouse:	**2,455** **5,418**	**2,468** **5,383**			

Data Source: Performance Based Contracting Database

Background: The SEE program (Services for Employment and Education) is a flexible, community-based service that provides access to an array of employment, skill training and educational opportunities for DMH clients. A range of employment services, including transitional, supported and independent employment *also* is provided in clubhouses. DMH provides the majority of funding for clubhouses in the state, and the clubhouses abide by standards that define their mission, membership and programs. Although most clubhouse members are referred by DMH and meet DMH eligibility criteria, members are not required to formally apply for DMH client eligibility to participate in the clubhouse programs. One of the felt needs in the area of employment is to improve DMH's ability to track employment tenure, in addition to placement.`

Significance: Employment is a means of enhancing self-esteem and independence and increasing community tenure for people with serious mental illness.

++

Objective I/4/3 A: **Increase community tenure (reduce recidivism) of adults discharged from CMHCs, acute and continuing care (state) hospitals.**

Brief Name: *Increased community tenure*

Indicator: the percent of adults readmitted to acute inpatient care within 7 days of discharge

Measure: # adults discharged from DMH CMHCs readmitted w/in 7 days
# of adults discharged from DMH CMHCs

Measure: # adults discharged from MBHP network hospitals readmitted w/in 7 days
# of adults discharged from MBHP network hospitals

Year 1: Recidivism among adults discharged from DMH CMHCs and MBHP network hospitals is maintained at no more than 6*%*

Year 2: Recidivism among adults discharged from DMH CMHCs and MBHP network hospitals is maintained at no more than *5%*

Year 3: Recidivism among adults discharged from DMH CMHCs and MBHP network hospitals is maintained at no more than *5%*

Indicator: the percent of adults readmitted within 30 days of discharge

Measure: # adults discharged from DMH CMHCs readmitted w/in 30 days
# of adults discharged from DMH CMHCs

Measure: # adults discharged from MBHP network hospitals readmitted w/in 30 days
# of adults discharged from MBHP network hospitals

Measure: # adults discharged from state hospitals readmitted w/in 30 days
# of adults discharged from state hospitals

Year 1: Recidivism among adults discharged from DMH CMHCs is no more than *13%;* recidivism among patients discharged from MBHP network hospitals is no more than *18%;* recidivism among patients discharged from state hospitals is no more than *5%*

Year 2: Recidivism among adults discharged from DMH CMHCs is no more than *13%;* recidivism among patients discharged from MBHP network hospitals is no more than *18%;* recidivism among patients discharged from state hospitals is no more than *5%*

Year 3: Recidivism among adults discharged from DMH CMHCs is no more than *13%;* recidivism among patients discharged from MBHP network hospitals is no more than *18%;* recidivism among patients discharged from state hospitals is no more than *5%*

Indicator: the percent of adults readmitted to state hospitals within 180 days of discharge

Measure: # adults discharged from state hospitals readmitted w/in 180 days
# of adults discharged from state hospitals

Year 1: Recidivism among adults discharged from state hospitals is no more than *17%*

Year 2: Recidivism among adults discharged from state hospitals is no more than *17%*

Year 3: Recidivism among adults discharged from state hospitals is no more than *17%*

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/3. *Increased community tenure*					
Value: % of adults readmitted to CMHCs within: 7 days after discharge: 30 days after discharge:	 **4.6%** **9.1%**	 **7%** **13%**	 **6%** **13%**	 **5%** **9.8%**	 **5%** **9.8%**
Numerator: # of adults readmitted to CMHCs within: 7 days after discharge 30 days after discharge	 **38** **76**	 **47** **87**			
Denominator: # of adults discharged from CMHCs	**834**	**671**			

Performance Measures:	SFY'03 Actual	SFY'04 Projected	SFY'05 Goal	SFY'06 Goal	SFY'07 Goal
I/4/3. *Increased community tenure (continued)*					
Value: % of adults readmitted to MBHP network hospitals 7 days after discharge: 30 days after discharge:	**1.5%** **19.5%**	**N/A**	**1.5%** **19.5%**	**1.5%** **19.5%**	**1.5%** **19.5%**
Numerator: # of adults readmitted to MBHP network hospitals within: 7 days after discharge 30 days after discharge	**151** **1,969**	**N/A**			
Denominator: # of adults discharged from MBHP network hospitals	**10,098**	**N/A**			
Value: % of adults readmitted to state hospitals within: 30 days after discharge 180 days after discharge		**5%** **17%**	**5%** **17%**	**5%** **17%**	**5%** **17%**
Numerator: # of adults readmitted to state hospitals within: 30 days after discharge 180 days after discharge		**86** **262**			
Denominator: # of adults discharged from state hospitals		**1,536**			

Data Source: DMH Data Warehouse and DMA/MBHP Database (does not include data from the DMH units at DPH hospitals)

Background: Most DMH clients receive acute inpatient services through the Department of Medical Assistance (DMA) and its behavioral managed care vendor, Massachusetts Behavioral Health Partnership (MBHP), in either DMH community mental health centers (CMHCs) or MBHP network hospitals. It is assumed, in most cases, that a readmission within 30 days indicates premature discharge or insufficient community support. DMH works with DMA and MBHP to achieve desired outcomes through performance improvement activities. State hospitals provide continuing (extended stay) care only and undertake extensive and careful planning before discharge. Even patients who petition for discharge, are deemed competent by a court, and refuse a residential referral or

discharge plan are tracked, to the extent possible, when they leave the hospital. They are encouraged to utilize DMH services when and if they are ready to do so.

Significance: Reducing the need for hospitalization and increasing community tenure is a major goal of DMH.

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Objective I/4/4 A: **Increase level of functioning for inpatients and community clients.**

Brief Name: *Improved functioning*

Indicator: the percent of adults receiving extended stay inpatient services and/or case management services with increased functioning at periodic reviews (inpatient) or at the annual Individual Service Plan (ISP) review (community) as measured by the CERF R (Current Evaluation of Risk and Functioning-Revised)

Measure 1: # of adults on extended stay inpatient units with increased functioning in 8 selected domains on most recent CERF-R
/
# of adults on extended stay inpatient units given the CERF-R who scored 5 or 6 at admission on any of 8 selected domains (A. ADL; E. Social; F. Independence; H. Medications; I. Negotiate Hazards; J. Violence – Others; L. Violence – Self; N. Substance Abuse)

Measure 2: # of adults in the community CERF-R showing increased functioning in 8 selected functional domains at annual ISP review
/
# of adults with an ISP given the CERF-R who scored 4 or more on previous CERF-R in any of 8 selected domains (A. Hygiene; B. Nutrition; E. Negotiate Social Situations; F. Pursue Independence; G. Use Recovery Services; H. Use Psychiatric Meds; I. Recognize/Avoid Common Hazards)

Year 1: Continuing Inpatient: Improve level of functioning/reduce risk. At periodic review CERF-R, score is increased in at least one of 8 selected domains where the patient scored a 5 or 6 at admission.

Level of functioning at ISP annual review CERF-R (community) is increased in at least one domain where the client scored a 4, 5 or 6 on any of 8 selected domains on the previous CERF-R.

Year 2: Same as Year 1.

Year 3: Same as Year 1.

NOTE: Both *functional* and *risk* domains from CERF-R were selected for inpatients, because many patients have serious *risk* issues at hospital admission. On the other hand, only *functional* domains were selected for the community clients because such a small percentage of community clients have high risk scores that to include risk domains would not give a representative sample of the issues for the vast majority of community clients.

Performance Measures:	SFY'03 Actual	SFY'04 Projected	SFY'05 Goal	SFY'06 Goal	SFY'07 Goal
I/4/4. *Improved functioning*					
Value: % adults with increased functioning (inpatient)	**53%**	**50%**	**50%**	**50%**	**50%**
Numerator: # adults on extended stay inpatient units with increased functioning on most recent CERF-R at periodic review	**358**				
Denominator: # of adults on extended stay inpatient units given the CERF-R who scored 5 or 6 at admission	**676**				
Value: % adults with increased functioning (community)	**53%**	**50%**	**50%**	**50%**	**50%**
Numerator: # of adults with an ISP with increased functioning at annual ISP review	**1,362**				
Denominator: # of adults with an ISP given the CERF-R who scored 4 or more on previous CERF-R	**2,569**				

Data Source: DMH Data Warehouse

Background: The CERF-R is used on all extended stay inpatient units and with every case managed DMH client in the community. A multidisciplinary team (inpatient) or team of providers and case manager (community) typically administers the CERF-R. CERF-R is administered to patients on inpatient units at the time of admission, at 3 and 6-month periodic reviews, at the annual review and at discharge. CERF-R is administered to community clients at the time of ISP development and at the ISP annual review. A score of 5 or 6 would indicate a relatively low level of functioning which would presumably improve after a period of hospitalization and be significantly improved at the time of discharge. A score of 4 or more (community clients) would trigger authorization of community services that would presumably improve functioning. Inpatient implementation of CERF-R occurred in SFY'00; and phased community implementation began in SFY'01.

Significance: Mental health services are expected to improve a person's ability to function in his/her environment. The CERF-R measures various domains related to autonomy and risk.
++

Goal I/5 A: Access to mental health services is increased.

Population: **Adults with serious mental illness**

Objective I/5/1 A: **Assign eligible DMH clients to community services in a timely way.**

Brief Name: *Access*

Indicator: the percent of adults receiving case management services and/or a DMH community service in a timely way after being determined eligible

Measure: # of eligible adults assigned to case management and/or a DMH community service
# of newly eligible adults (in a given fiscal year)

Year 1: *65%* of eligible DMH clients are assigned to case management and/or another DMH community service within 90 days of eligibility determination

Year 2: *65%* of eligible DMH clients are assigned to case management and/or another DMH community service within 90 days of eligibility determination

Year 3: *65%* of eligible DMH clients are assigned to case management and/or another DMH community service within 90 days of eligibility determination

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/1. *Access*					
Value: the % of adults receiving case management services and/or a DMH community service within 90 days of eligibility determination	**29%**	**65.5%**	**65%**	**65%**	**65%**
Numerator: # of eligible adults assigned to case management and/or a DMH community service within 90 days of eligibility determination	**638**	**915**			
Denominator: # of newly eligible adults	**2,220**	**1,397**			

Data Source: DMH Data Warehouse

Background: After an individual applies for DMH eligibility and is determined by DMH to meet clinical and other criteria, assignment to community services is based on the intensity of the person's need and the availability of services. Although there are waiting lists for high demand and high intensity services, such as case management, PACT and residential services, most clients are assigned to a less intensive service while waiting.
++

Objective I/5/2 A: **Ensure that adults referred from acute care hospitals to DMH are either admitted for hospital level of care (LOC) or diverted to a less restrictive, clinically appropriate community-based alternative.**

Brief Name: *Inpatient referrals*

Indicator: the percent of individuals referred from acute care to DMH and admitted to hospital LOC or diverted to a clinically appropriate community alternative

Measure: # of hospital admissions & community diversions
# of referrals to DMH from acute care

Year 1: *80%* of non-forensic patients admitted for hospital LOC; *20%* diverted to community alternative

Year 2: *80%* of non-forensic patients admitted for hospital LOC; *20%* diverted to community alternative

Year 3: *80%* of non-forensic patients admitted for hospital LOC; *20%* diverted to community alternative

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/2. *Inpatient admissions*					
Value: % referrals admitted for hospital LOC: diverted to community:		**80%*** **20%***	**80%** **20%**	**80%** **20%**	**80%** **20%**
Numerator: # of hospital admissions: community diversions:		**84*** **21***			
Denominator: # of referrals to DMH from acute care		**105***			

***Data Source**: Metro Suburban Area Office (data are from one Area only – see below)

Background: Admission to DMH extended stay inpatient facilities is based on published, uniform clinical criteria and available beds. Referrals are accepted from all acute hospitals as well as from the courts. All forensic patients are admitted. When indicated, DMH staff, e.g., case managers, PACT team, housing specialists, work

intensively with non-forensic patients from the referring acute care hospital to find an appropriate alternative to hospital level of care. This may include return to a residence, with necessary support, or community respite care.

The SFY'04 data above are from a single DMH Area, Metro Suburban - the largest area in the state. These data have been "cleansed" to remove extraneous factors that incorrectly contaminated previous statewide data, such as forensic referrals and referrals from the acute facility that were withdrawn. The SFY'04 Implementation Report (due December 1, 2004) will include complete data for all six DMH Areas and the SFY'05, '06 and '07 goals will be recalculated, if necessary. Data from SFY'03 are not displayed because they are also contaminated.

Significance: Access to services is a major goal of DMH. The central aim of service delivery is to integrate public and private services and resources to provide continuity of care.

++

Objective I/5/3 A: Ensure that clients participate actively in their treatment planning.

Brief Name: *Participation in treatment planning*

Indicator: the percent of DMH-eligible adults that were satisfied with their participation in treatment planning

Measure: # of adults satisfied with their participation in treatment planning
# of adults surveyed

Year 1: Planning is undertaken to develop a survey that measures client satisfaction with participation in treatment planning.

Year 2: A survey is completed and piloted that measures client satisfaction with participation in treatment planning.

Year 3: TBD% of individuals surveyed are satisfied with their participation in treatment planning.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/3 *Participation in treatment planning*					
Value: % adults satisfied with their participation in treatment planning			**Plan for survey**	**Pilot survey; establish baseline**	**TBD**
Numerator: # of adults satisfied with their participation in treatment planning					
Denominator: # of adults surveyed					

Data Source: DMH Data Warehouse

Background: DMH Service Planning regulations encourage clients and/or their guardians to participate actively in treatment planning. Every effort is made to engage clients in this process in a way that is comfortable for them. The Department expects all clients and/or their guardians to participate in treatment planning, if they are willing and able to do so. DMH has had difficulty in the past several years getting reliable data to track this indicator. However, improvements are planned to the Data Warehouse that will greatly enhance our ability to get accurate data. DMH recognizes that the client's perception of the quality of participation is very important. In that regard, DMH plans to utilize a consumer survey instrument to measure the quality of participation, in at least a significant sample of the population.

Significance: With its emphasis on rehabilitation, DMH seeks active participation by clients in decisions regarding treatment. Client participation is a "best practice" and fosters collaboration.

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Objective I/5/4 A: **Develop and implement services for clients who are deaf, hard of hearing or late deafened.**

Brief Name: *Deaf services*

Indicator: the percent of DMH clients who are deaf, hard of hearing or late deafened receiving appropriate services and communication access

Measure: # of DMH clients who are deaf, hard of hearing or late deafened assigned to deaf-sensitive services, including appropriate communication access / # of DMH clients who are deaf, hard of hearing or late deafened

Year 1: *60%* of DMH clients who are deaf, hard of hearing or late deafened are assigned to community services with appropriate communication access

Year 2: *80%* of DMH clients who are deaf, hard of hearing or late deafened are assigned to community services with appropriate communication access

Year 3: *90%* of DMH clients who are deaf, hard of hearing or late deafened are assigned to community services with appropriate communication access

Performance Measures:	SFY'03 Actual	SFY'04 Projected	SFY'05 Goal	SFY'06 Goal	SFY'07 Goal
I/5/4. *Deaf services*					
Value: % adults receiving deaf-sensitive services with communication access			**60%**	**80%**	**90%**
Numerator: # of DMH clients receiving services with communication access		**169** (receiving a DMH service, but may lack appropriate communcation access)			
Denominator: # of DMH clients who are deaf, hard of hearing or late deafened	**127**	**174**			

Data Source: DMH Deaf Services Coordinator; DMH Data Warehouse (includes 5 of 6 DMH Areas and may include a stay in the deaf inpatient unit as well as community services).

Background: As described above, DMH has undertaken to centrally coordinate the provision of services to this special population. The coordinator, a social worker who is fluent in ASL and culturally competent in deafness, provides clinical oversight and consultation to the field. Although most deaf or hard of hearing clients receive DMH services, they may not be able to communicate optimally through TTY, interpreters, etc. A principal goal is to assign them to case managers and/or other community services that afford full communication access. Three new qualified social workers will be hired in SFY'05 and four new residential slots have been created. As funding becomes available, community services will be added or expanded.

Significance: Increasing access to services is a major goal of DMH.
++

Objective I/5/5 A: **Encourage the use of Emergency Service Programs (ESP) by elders (>65), particularly elders-at-risk, by ensuring that ESPs have staff that is knowledgeable and experienced in working with elders.**

Brief Name: *Elder emergency services*

Indicator: the number of elders who are screened and evaluated by an ESP

Measure: # of elderly individuals who are screened and evaluated by an ESP

Year 1: ESPs are assessed for their capability to screen and evaluate elders with appropriately trained staff and provide home visits

Year 2: Recontracting process requires ESPs to assure that staff have specialized knowledge and training to screen and evaluate elders, at the ESP site or at home, and to monitor compliance with this expectation; a baseline is established to determine # of elders who contact an ESP and are screened and evaluated

Year 3: Increase # of elderly individuals who are screened and evaluated by an ESP

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/5. *Elder emergency services*					
Value: # elders who are screened and evaluated by an ESP	**N/A**	**N/A**	**Survey is completed**	**ESP Recontract-ing includes elder needs; baseline established**	**# screened & evaluated TBD**

Data Source: MBHP Database and DMH Warehouse (for state-operated programs)

Background: Currently, very few elders or elder-serving agencies use ESPs, who could play a significant role in helping elders to stay in the community - out of nursing homes and not involuntarily committed to hospitals - with proper supports. There are a number of reasons why elders do not seek or receive adequate or appropriate mental health services. One reason is stigma. Another is that there is little awareness in the elder community that this service exists and confusion as to who is eligible to use it (i.e., Medicare, uninsured). The other is that services tailored to their particular needs, provided by staff who are trained and knowledgeable in serving this population, may not be available. It is particularly important that elders-at-risk, i.e., those unable to provide self-care, are screened, evaluated and appropriately referred. In addition to increasing the accessibility of this resource, it will be important to educate elders and elder-serving agencies to assure its appropriate and continued use. This can be done through linkage with the Executive Office of Elder Affairs and the coalition of advocates that are already connected to DMH for the purpose of developing an elder mental health plan.

Significance: Increasing access to services is a major goal of DMH.

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Goal I/6 A: Change the culture and improve staff-client interaction in DMH-facilities to reduce the need for mechanical and chemical restraint

Population: Adults in DMH inpatient facilities

Objective I/6 A: Reduce incidents of restraint in DMH facilities

Brief Name: *Restraint Reduction*

Indicator: the number of reported incidents of restraint (per 1,000 patient days) in DMH inpatient facilities

Measure: the % decrease of reported incidents of restraint in DMH inpatient facilities

Year 1: DMH will develop a curriculum, provide training on the curriculum and develop a system to monitor how facilities achieve and maintain core competencies. A baseline (mean of '03/'04/'05) will be established.

Year 2: Reduce the rate of restraint by *25%* (over mean of SFY'03/'04/'05)

Year 3: Reduce the rate of restraint by *50%* (over mean of SFY'03/'04/'05)

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/6 A. *Restraint Reduction*					
Value: the % reduction of reported incidents of restraint (per 1,000 patient days) in DMH inpatient facilities			**Collect & analyze '03/04/05 data for baseline**	**25% reduction from baseline**	**50% reduction from baseline**
Measure: # of reported incidents of restraint (per 1,000 patient days)	**10.96** (# of incidents per 1,000 patient days in *calendar* 2003)	**N/A**			

Data Source: DMH Licensing Division, Seclusion and Restraint Database

Background: The DMH collects monthly statewide restraint and seclusion (R/S) data from all licensed, state-operated and state-contracted inpatient units and facilities. DMH has been actively engaged for more than three years in an intense Restraint-Reduction Initiative in the licensed and contracted child and adolescent units and facilities in the Commonwealth, and began a focused initiative to extend this initiative to its adult state hospitals in SFY'03. Staff from two of the state hospitals participated in a national training exercise in SFY'04, but all of the state facilities will participate in restraint reduction activities. As in the child-adolescent system, the goal is to effect major culture change, augmented by changes in regulations and policies that support a restraint and seclusion-free environment. In SFY'05, DMH will develop a curriculum, provide training on the curriculum for all of its facilities, and develop a mechanism to monitor ongoing fidelity to the core competencies and capacity to comply with recommendations and interventions in the training curriculum. In SFY'05, DMH will collect and analyze R/S statistics (restraint data are received from each facility monthly) to provide a baseline to be used in analyzing data in SFY'06 and '07.

Significance: Reducing the use of restraint and seclusion is a best practice.

Objective I/7 A: Survey consumers to assess whether DMH services result in improved outcomes

Brief Name: *Consumer Satisfaction*

Indicator: the percent of adults who report improvement in symptoms, functioning and/or quality of life as a result of receiving DMH services

Measure: # adults who report improvements in their symptoms, functioning and/or quality of life
adults surveyed

Year 1: Conduct research to select a tool and methodology for carrying out a statewide consumer satisfaction survey that measures outcomes

Year 2: Based on recommendations of research group, select a tool and methodology and begin data collection and analysis based on completed pilot survey

Year 3: Conduct full survey and analyze results

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/7-A. *Consumer Satisfaction*					
Value: the % of adults who report improvements in symptoms, functioning and/or quality of life as a result of receiving DMH services	**N/A**	**N/A**	**Select tool and methodology**	**Pilot survey; collect and analyze data**	**TBD**
Numerator: # of adults surveyed, who report improvements	**N/A**	**N/A**			
Denominator: # of adults surveyed	**N/A**	**N/A**			

Data Source: Consumer Quality Initiatives, Inc.; DMH Div. of Mental Health Services

Background: For a number of years, DMH has contracted with Consumer Quality Initiatives, Inc. (CQI), a Boston-based consumer-run organization, to conduct consumer satisfaction surveys in some of its programs. Included were adult DMH inpatient, case management, residential and PACT programs, to name a few. These surveys, which are conducted via face-to-face interviews, have been well received. In addition, every program (i.e., adult, child and adolescent) that contracts with DMH is required to survey its own service recipients to assess satisfaction with the program. Programs report the results annually to DMH through Performance Based Contracting (PBC) and the results are compiled in the PBC database. However, the PBC program-based surveys have never been tested for validity and reliability.

In order to collect satisfaction and outcome data for the block grant and for the Uniform Reporting System Table 11, DMH will begin, in SFY'05, to develop a more comprehensive plan for conducting a statewide consumer survey, using a tool that has been tested and proven reliable. We will use the first year to research the tools and methodologies available for conducting this kind of survey. The survey will be piloted during Year 2 and fully implemented during Year 3. It is anticipated that the results of the survey will be used to inform program development and service delivery.

Criterion I: Issues Pertinent to Children, Adolescents and Transition-age Youth

Access to and Availability of Services

With the changes in the structure of the delivery of mental health services previously described, DMH now provides a range of continuing care community services. These include residential and intensive residential, case management, day services, supported education and skills training, therapeutic foster care, individual and family flexible support, including in-home treatment and respite care, and parent support that is open to the community. Although funding for children's mental health services has been held "harmless" in recent budgets, in spite of general budget cuts, there is acknowledgement that access to services for this population is still less than ideal.

DMH also contracts for extended stay inpatient services for adolescents. While the Department continues to provide emergency services in one DMH Area, most of the children and adolescents who were formerly served in DMH-contracted emergency programs are now served in Emergency Service Programs managed by the DMA's contracted behavioral health vendor (MBHP).

Each of the six DMH Areas assesses its needs, and develops and manages its programs, mostly through contracts with local providers. Only forensic mental health services and the statewide extended-stay inpatient and intensive residential treatment programs for children and adolescents are managed centrally, including two Behaviorally Intensive Residential Treatment programs that DMH developed for DSS youngsters.

A principal measure of accessibility is the ease with which families are able to apply for services and the length of time they must wait before those services are available. In that spirit, DMH will attempt to measure the Department's success in this arena. DMH continues to amend its application process to make it easier for families to gain access to services, including distribution of a brochure for individuals and families that provides "how to" guidance.

Quality Improvement

DMH has sought to assure that the administration of medications to children and adolescents in residential programs is being properly managed and that a system is in place to note side effects appropriately. Therefore, DMH residential program contracts require that a licensed nurse administer all medications. Recommendations emerging from the Suicide Prevention Task Force, the planned consumer and family satisfaction surveys, the Restraint and Seclusion Initiative and research on evidence based practices are expected to inform changes in service delivery.

Services for Clients with Special Needs

Children and adolescents with special needs receive care in the community. Planning and program development for these clients often take place at a variety of levels, however, due either to low incidence or the need for specialized services.

Deaf and Hard of Hearing

DMH continues to work with the Massachusetts Commission for the Deaf and Hard of Hearing around issues of referrals and eligibility determination, and communication access to appropriate services and case management.

Co-occurring Serious Emotional Disturbance and Substance Abuse Disorder

An interagency forum, originally convened by the Commissioner of DPH to look at the needs for training or access to substance abuse treatment services for children and adolescents and their families, has been reorganized as a Substance Abuse Task Force, and charged with developing a strategic plan for adolescents. In addition to DMH and DPH, the Task Force includes the Departments of Social Services, Youth Services, Mental Retardation and Transitional Assistance, DMA, the Juvenile Court and the Office of Child Care Services. The Parent Professional Advocacy League (PAL) was recently invited to participate, adding the family voice to planning. DMH and PAL's concern is to assure that adolescents with co-occurring disorders can access appropriate services.

Children Whose Parent(s) have Serious Mental Illness

The Family Project and the Parenting Options Project address the special parenting needs and challenges of adults with mental illness and their children, issues that are often overlooked in traditional treatment settings. Both projects are carried out through collaboration between clinicians and academic researchers at UMass Medical School and a group of DMH-funded clubhouses. DMH and UMass staff, as well as advocates from PAL, clubhouses and the consumer-run Cole Resource Center at McLean Hospital, are active participants on a steering committee that has been investigating ways of broadening accessibility to the expertise developed by these projects. A book for parents that grew out of this endeavor was published in August 2001 ("Parenting Well When You're Depressed" by Joanne Nicholson, Ph.D. et al.). Support from the National Association of Public Interest Lawyers, Massachusetts Bar Foundation, DMH (block grant) and Mental Health Legal Advisor's Committee is enabling the Parenting Options Project to continue providing legal assistance to parents, primarily in clubhouses, and supporting the development of protocols for use by other attorneys and parents.

In developing Individual Service Plans (ISP), DMH has begun to discuss how the needs of the entire family should be referenced within the ISP in addition to the needs of the identified client. This affirms the increasing recognition of the importance of family in assessing the needs of and planning services for adults.

To serve parents with mental health problems involved with DSS, DMH and DSS are developing regionally based collaborative training programs and protocols to assure that individual or family service plans provide parents with needed services and supports.

Transition-Age Youth

The Department continues to be concerned about the insufficient supply of age-appropriate services for transition age youth, defined as those between the ages of 16 and 25. This category includes older adolescents who meet the adult eligibility criteria as well as those who do not meet the criteria, but who, nonetheless, lack the skills to live independently without some services and/or supports.

DMH continues to offer supported education and skills training to *30* transition age youth, but budget cuts in SFY'02-'04 forced postponement of plans to expand the capacity of this service. In SFY'02, DMH organized a Youth Development Committee, including adolescents, young adults, parents, transition experts and other professionals, to focus on transition age programming, and to create a voice for youth. This group was accepted as a subcommittee of the State Mental Health Planning Council and has already undertaken a number of challenging projects, including a writing project and a survey.

DMH is using block grant funds and has contracted with M*Power, a consumer-run organization, to create a peer-mentoring project to assist youth transitioning from child/adolescent to adult services. In addition, Consumer Quality Initiatives, Inc. has interviewed individuals who transitioned from the child/adolescent into the adult service system to inform future DMH policy and programming in this area.

Forensic Mental Health Services

DMH has a long history of providing forensic mental health services to the juvenile justice system and to DMH facilities, including DMH contracted adolescent residential units. In SFY '99, the DMH Forensic Division assumed responsibility for procuring and managing all clinical services for the statewide Juvenile Court. Forensic specialists sited in the juvenile courts provide evaluation and consultation services for judges and probation officers on an as-needed basis, as well as treatment for children.

DMH is in the early planning stages of several initiatives that will affect individuals in the juvenile justice system. One goal is to identify, standardize and implement protocols between DYS (the juvenile justice service system) and DMH, MBHP, court clinics, DSS and Probation to assure timely information sharing and thoughtful transition planning for youth with mental health needs in the DYS system, and provide consultation (eligibility review) by DMH clinicians to DYS staff when necessary. A second goal is to develop a response to the increasing population of mentally ill and violent youth who are not adequately served within the DMH or DYS systems. A third goal is to develop more robust detention strategies to reduce the number of youth with mental health needs entering the detention system. And finally, there is a goal to increase options for diversionary levels of care for children seen in juvenile court clinics, and enhance coordination of services between court clinics and emergency service programs. As these projects begin to take shape, performance measures and indicators will be developed and added to the Plan.

Parent Support

DMH supports a number of initiatives that provide support to parents of children with SED. These include DMH Parent Coordinators in each Area, parent support groups, advocacy activities and more. Initially supported with DMH funds, NAMI-MASS and PAL provide "Visions for Tomorrow" courses. Designed for families and caregivers, course topics include: bipolar disorder, brain biology, depression, conduct disorder, anxiety disorders, obsessive-compulsive disorders, post-traumatic stress disorders, ADD/ADHD, phobias and childhood psychosis. Classes also cover: parents as case managers, communication skills, coping, rehabilitation, recovery and stigma.

In developing Individual Service Plans (ISP), DMH has begun to work on referencing the strengths and needs of the entire family, in addition to the needs of the identified client, in its service planning. Prompts to ensure that this information is gathered have been developed by the Southeastern Area and disseminated statewide. This affirms the increasing recognition of the importance of family in assessing the needs of and planning services for children and adolescents.

The executive director of PAL continues to co-chair Medicaid's Family Advisory Committee. In addition, PAL receives funding from the state's major insurance companies to maintain a statewide toll-free telephone line to assist parents, youth and others in navigating the public and private child service systems, and to address issues concerning special education and health insurance.

CRITERION I - CHILD/ADOLESCENT PERFORMANCE INDICATORS

Goal I/1 C/A: The Department addresses the mental health needs of people in the Commonwealth.

Population: **Children and adolescents with emotional disturbance**

Objective I/1/1 C/A: Prepare for coordinating and delivering mental health services in the event and/or aftermath of a natural or man-made disaster.

Brief Name: *Disaster Management*

Indicator: DMH collaborates with its community partners to foster resilience and preparedness, and increase stress management skills among children and adolescents and their families before any untoward event.

Measure: The Commonwealth prepares for and responds to the mental health needs of its citizens in the event of a disaster.

Year 1: Develop an evidence-based, culturally competent and developmentally appropriate program to train licensed mental health professionals to respond appropriately and quickly in the event of a natural and/or man-made disaster; train 75 crisis counselors per quarter.

Year 2: Continue to train 75 crisis counselors per quarter; develop official credentialing criteria for crisis counselors and integrate their certification with certification criteria being developed by DPH for health care volunteers.

Year 3: Continue to train 75 crisis counselors per quarter; identify trained DMH crisis counselors in each DMH Area to function as liaisons with regional DPH and Department of Homeland Security planning groups to ensure that behavioral health issues are included in all aspects of disaster planning and management.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/1. *Disaster Management*					
Value/Measure: Massachusetts prepares for and responds to the mental health needs of its citizens in the event of a disaster	Post-9/11 counseling provided	DPH grant received; DMH role defined	Training curriculum designed; 75 clinicians trained	Credential process designed; 75 clinicians trained	DMH-DPH-DHS liaison created; 75 clinicians trained

Data Source & Background: Please see narrative, page 53.

Significance: The Department's enabling statute requires DMH to take cognizance of the mental health needs of the citizens of the Commonwealth.

Objective I/1/2 C/A: Continue efforts to reduce the stigma associated with mental illness and serious emotional disturbance

Brief Name: *Reducing stigma*

Indicator: Attitudes of high school teachers and administrators toward mental health issues are improved.

Measure: The EBI is implemented in selected high schools across the Commonwealth

Year 1: Training on the EBI school curriculum is provided to teachers and administrators in four pilot high schools. The curriculum is included as in-service training to the professional staff in these four schools.

Year 2: Training on the EBI school curriculum is provided to teachers and administrators in four additional high schools. The curriculum is included as in-service training to the professional staff in these four schools.

Year 3: Teachers and administrators in the selected schools are surveyed to determine the impact of the training

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/2. *Reducing Stigma*					
Value: The EBI is implemented in selected high schools across the Commonwealth.	**Mass. selected for EBI**	**Materials developed; pilot schools recruited**	**Training provided to four schools**	**Training provided to four more schools**	**Schools are surveyed; survey measures impact of training**

Data Source: DMH Office of Policy Development; Mass. Association for Mental Health

Background: DMH launched a successful statewide anti-stigma campaign in 1997. A survey this past year demonstrated that public attitudes have changed since that time and that people are more willing to seek help for emotional problems. There is still a long way to go, however. In 2003, Massachusetts was selected by SAMHSA as one of eight states to pilot its new anti-stigma campaign called, "Elimination of Barriers Initiative (EBI)." In addition to PSAs for TV and radio and print articles targeted to the general population, a more specific campaign, which includes a curriculum approved by SAMHSA for high school teachers and administrators, is being rolled out in SFY'05. DMH has partnered with the Massachusetts Association for Mental Health in this effort.

Significance: Decreasing stigma promotes increased utilization of mental health services.
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Goal I/2 C/A: DMH clients receive coordinated and integrated services.

Population: **Children and adolescents with serious emotional disturbance**

Objective I/2/1 C-A: Maintain or increase the number of children and adolescents receiving case management services.

Brief Name: *Case Management*

Indicator: the percent of children and adolescents receiving case management services

Measure: # of children and adolescents receiving case management services
# of eligible children and adolescent clients

Year 1: *53%* of eligible children and adolescents receive case management

Year 2: *53%* of eligible children and adolescents receive case management

Year 3: *53%* of eligible children and adolescents receive case management

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/2/1. *Case Management*					
Value: the % of children and adolescents receiving case management services	**55%**	**53.1%**	**53%**	**53%**	**53%**
Numerator: # of children and adolescents receiving case management services	**1,975**	**1,871**			
Denominator: # of eligible children and adolescent clients	**3,579**	**3,523**			

Data Source: DMH Data Warehouse

Objective I/2/2 C/A: Survey the families of children and adolescents receiving case management services to determine if they perceive this service positively

Brief Name: *Case management effectiveness*

Indicator: the percent of families of case managed children and adolescents who perceive case management positively

Measure: # of families of case managed children and adolescents surveyed, who perceive case management positively
# of families of children & adolescents receiving case management services surveyed

Year 1: Planning year for developing a consumer satisfaction survey

Year 2: TBD% of children, adolescents and families surveyed who perceive case management positively

Year 3: TBD% of children, adolescents and families surveyed who perceive case management positively

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/2/2. *Case management effectiveness*					
Value: the % of families of case managed children and adolescents who perceive case management positively			**Planning for survey**	**TBD**	**TBD**
Numerator: # of families of case managed children and adolescents surveyed, who perceive case management positively					
Denominator: # of families of children & adolescents receiving case management services surveyed					

Data Source: Consumer Quality Initiatives, Inc.; DMH Div. of Mental Health Services

Background: Despite the early retirements, hiring freezes and job reorganizations of recent years, DMH has retained a stable number of case managers and is committed to at least maintaining case management services at the SFY'04 level. Through development of a consumer satisfaction survey, DMH will gauge the effectiveness of these sought after services, as perceived by clients and families.

Special Issues: Additional funding is necessary to increase the number of case managers.

Significance: Case management services provide the integration and coordination necessary to support clients' ability to live independently in the community and reduce the need for hospitalization.

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Goal I/3 C/A: DMH clients in residential programs improve ability to manage their mental health problems.

Population: Children and adolescents with SED in residential programs

Objective I/3 C/A: Ensure that clients in DMH residential programs are better able to manage their mental health problems.

Brief Name: *Residential Services*

Indicator: the percent of children and adolescents in DMH residential programs who report increased ability to manage mental health problems

Measure: # of children and adolescents who report increased ability to manage their mental health problems / # of children and adolescents responding to survey

Measure: # of families reporting child's increased ability to manage mental health problems / # of families responding to survey

Year 1: Maintain or increase # of children and adolescents who report they are better able to manage their mental health problems

Year 2: Maintain or increase # of children and adolescents who report they are better able to manage their mental health problems

Year 3: Maintain or increase # of children and adolescents who report they are better able to manage their mental health problems

Performance Measures:	**SFY'03 Actual**	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/3 (a) *Residential Services*					
Value: % of children and adolescents in DMH residential programs who report increased ability to manage their mental health problems	**90%**	**91%** (9 of 27 programs reporting)	**90%**	**90%**	**90%**
Numerator: # of children and adolescents who report increased ability	**326**	**162**			
Denominator: # of children and adolescents responding to survey	**360**	**177**			

Year 1: Maintain or increase # of families who report their children are better able to manage their mental health problems

Year 2: Maintain or increase # of families who report their children are better able to manage their mental health problems

Year 3: Maintain or increase # of families who report their children are better able to manage their mental health problems

Performance Measures:	SFY'03 Actual	SFY'04 Actual	SFY'05 Goal	SFY'06 Goal	SFY'07 Goal
I/3 (b) *Residential Services*					
Value: % of families of children and adolescents in DMH residential programs who report increased ability to manage their mental health problems	**92%**	**82%** (9 of 27 [programs reporting)	**90%**	**90%**	**90%**
Numerator: # of families who report increased ability	**296**	**136**			
Denominator: # of families responding to survey	**320**	**166**			

Data Source: Performance Based Contracting

Background: All contracted residential treatment providers are required to survey the residents of the programs, and their families, annually, on a number of issues. One measure is the child's perception of increased ability to manage his/her mental health problems. A second is the family's perception of the same measure. **Note**: Due to a data management problem that has since been resolved, SFY'04 data for only 9 of 27 programs have been entered into the Performance Based Contracting System as of this writing.

Significance: The goal of community residential treatment is to increase child or adolescent's ability to manage his/her problems and return to a less restrictive setting.
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Goal I/4 C/A: Children and adolescents achieve maximum independence and highest functioning.

Population: **Children and adolescents with serious emotional disturbance**

Objective I/4/1 C/A: Increase community tenure (reduce recidivism) of children and adolescents discharged from acute care (MBHP network) hospitals.

Brief Name: *Reduced recidivism (acute care)*

Indicator: the number of children and adolescents readmitted to acute inpatient care within 30 days of discharge

Measure: # C/A discharged from MBHP network hospitals readmitted w/in 30 days
# of C/A discharged from MBHP network hospitals

Year 1: No more than *12%* of children and 15% of adolescents discharged from MBHP network hospitals will be readmitted within 30 days of discharge

Year 2: No more than *12%* of children and 15% of adolescents discharged from MBHP network hospitals will be readmitted within 30 days of discharge

Year 3: No more than *12%* of children and 15% of adolescents discharged from MBHP network hospitals will be readmitted within 30 days of discharge

Objective I/4/2 C/A: Increase community tenure (reduce recidivism) of children and adolescents discharged from state hospitals.

Brief name: *Reduced recidivism (extended stay)*

Indicator: the percent of adolescents readmitted to state hospitals within 30 days of discharge

Measure: # adolescents discharged from state hospitals readmitted w/in 30 days
# of C/A discharged from state hospitals

Year 1: No more than *5%* of adolescents discharged from state hospitals will be readmitted within 30 days of discharge

Year 2: No more than *5%* of adolescents discharged from state hospitals will be readmitted within 30 days of discharge

Year 3: No more than *5%* of adolescents discharged from state hospitals will be readmitted within 30 days of discharge

Indicator: the percent of adolescents readmitted to state hospitals within 180 days of discharge

Measure: # adolescents discharged from state hospitals readmitted w/in 180 days
# of adolescents discharged from state hospitals

Year 1: No more than *7.6%* of adolescents discharged from state hospitals will be readmitted within 180 days of discharge

Year 2: No more than *7.6%* of adolescents discharged from state hospitals will be readmitted within 180 days of discharge

Year 3: No more than 7.6% of adolescents discharged from state hospitals will be readmitted within 180 days of discharge

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/1. *Reduced recidivism (acute care)*					
Value: % readmitted to MBHP network hospitals Children: Adolescents:	 **11.9%** **14.7%**	 **N/A**	 **12%** **15%**	 **12%** **15%**	 **12%** **15%**
Numerator: # readmitted to network hospitals within 30 days after discharge Children: Adolescents:	 **175** **285**	**N/A**			
Denominator: # discharged from network hospitals Children: Adolescents:	 **1,471** **1,938**	**N/A**			
1/4/2. *Reduced recidivism (extended stay)*					
Value: % of adolescents readmitted to state hospitals 30 days: 180 days:	 **4%** **7.6%**	 **5%** **7.6%**	 **5%** **7.6%**	 **5%** **7.6%**
Numerator: # adolescents readmitted to state hospitals within: 30 days after discharge 180 days after discharge	 **3** **5**				
Denominator: # of adolescents discharged from state hospitals		**66**			

Data Source: DMH Data Warehouse and DMA/MBHP database

Background: Many children and adolescents receive acute inpatient services through the Department of Medical Assistance (DMA) and its behavioral managed care vendor, MBHP, in MBHP network hospitals. There is concern that readmission within 30 days may be an indicator of premature discharge or inadequate aftercare. One factor that must be considered is the consequence of placing a child in a hospital far from home (due to lack of a closer bed), resulting in more difficult monitoring of after care services. State hospitals provide continuing (extended stay) care only and undertake extensive and careful planning before discharge.

Significance: Reducing the need for hospitalization and increasing community tenure is a major goal of DMH.

Objective I/4/3 C/A: Improve level of functioning of children and adolescents receiving community services.

Brief Name: *Improved functioning*

Indicator: The percent of case managed C/A with increased functioning at the annual Individual Service Plan (ISP) review as measured by the CAFAS (Child and Adolescent Functioning Assessment Scale)

Measure: # of children/adolescents with an ISP with increased functioning
# of children/adolescents with an ISP given the CAFAS

Year 1: Increase level of functioning, as measured by CAFAS at annual review, compared to baseline (eligibility determination).

Year 2: Increase level of functioning, as measured by CAFAS at annual review, compared to baseline (eligibility determination).

Year 3: Increase level of functioning, as measured by CAFAS at annual review, compared to baseline (eligibility determination).

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/3 *Improved functioning*					
Value: % children with increased functioning	**49.8%**	**55.7%**	**55%**	**55%**	**55%**
Numerator: # of children and adolescents with an ISP with increased functioning	**152**	**142**			
Denominator: # of children/adolescents with an ISP given the CAFAS	**305**	**255**			

Data Source: DMH Data Warehouse

Background: The CAFAS is used with every case managed DMH client in the community, at the time of eligibility determination (ISP development) and again at the time of the ISP annual review. DMH case managers have been specially trained to administer the CAFAS. Administering the CAFAS to all children at the time of annual review was implemented in January 2001 and the Department's Mental Health Information System has been modified to accept CAFAS scores, a necessary prerequisite for analyzing the data. Although we are able to compare the two sets of scores for each child to determine level of functioning (i.e., increased or decreased), there is insufficient research and/or data to set a percentage goal for improvement or to predict whose functioning will improve as demonstrated on CAFAS. The analysis may help case managers and clinicians assess the appropriateness of the service array.

Significance: Mental health services are expected to improve a person's ability to function in his/her environment. The CAFAS measures various domains related to functioning.

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Goal I/5 C/A: Access to mental health services is increased.

Population: **Children and adolescents with serious emotional disturbance**

Objective I/5/1 C/A: Assign eligible DMH clients to community services in a timely way.

Brief Name: *Access*

Indicator: the percent of children and adolescents receiving case management services and/or a DMH community service in a timely way after being determined eligible

Measure: # of eligible children and adolescents assigned to case management and/or a DMH community service
# of newly eligible children and adolescents (in a given fiscal year)

Year 1: *56.8%* of eligible DMH children and adolescents are assigned to case management and/or another DMH community service within 90 days of eligibility determination

Year 2: *56.8%* of eligible DMH children and adolescents are assigned to case management and/or another DMH community service within 90 days of eligibility determination

Year 3: *56.8%* of eligible DMH children and adolescents are assigned to case management and/or another DMH community service within 90 days of eligibility determination

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/1. *Access*					
Value: the % of C & A receiving case management services and/or a DMH community service after being determined eligible	**55.5%**	**56.8%**	**56.8%**	**56.8%**	**56.8%**
Numerator: # of eligible children and adolescents assigned to case management and/or a DMH community service within 90 days	**627**	**521**			
Denominator: # of children and adolescents found eligible (in a given fiscal year)	**1,130**	**917**			

Data source: DMH Data Warehouse

Background: After an individual applies for DMH eligibility and is determined by DMH to meet clinical and other criteria, assignment to community services is based on the intensity of the person's need and the availability of services. Despite waiting lists for high demand and high intensity services, such as case management and residential services, most clients are assigned to a less intensive service while waiting.

Significance: Timely access to services is critical.
++

Objective I/5/2 C/A: Parents and/or guardians participate actively in the development of their child's/ward's treatment plan.

Brief Name: *Quality of participation in treatment planning*

Indicator: the percent of legally authorized representatives (parents and guardians) who participate actively in treatment planning for DMH eligible children and adolescents under 18

Measure: # of families satisfied with their participation in treatment planning
# of families surveyed

Year 1: Planning is undertaken to develop a survey that measures client satisfaction with participation in ISP treatment planning.

Year 2: A survey is completed and piloted that measures client satisfaction with participation in ISP treatment planning.

Year 3: TBD% of families surveyed are satisfied with their participation in treatment planning.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/2. *Quality of participation in treatment planning*					
Value: % families satisfied with their participation in treatment planning			**Planning for survey**	**Survey piloted; baseline established**	**TBD**
Numerator: # of families satisfied with their participation in treatment planning	**N/A**	**N/A**			
Denominator: # of families surveyed	**N/A**	**N/A**			

Data Source: DMH Data Warehouse

Background: Parents and/or guardians of minors, and minors when they are capable, have always been encouraged to participate actively in treatment planning. The Department expects *100%* of parents and/or guardians of minors to authorize treatment. The parent or guardian must approve and sign the ISP before services can begin, and all of the children with ISPs are receiving services. DMH has had difficulty in the past several years getting reliable data to track this indicator. However, improvements are planned to the Data Warehouse that will greatly enhance our ability to get accurate data. The ISP is an important part of treatment planning, but not the only part. In addition to tracking ISP participation, DMH recognizes that the LAR's perception of the quality of participation is equally important. In that regard, DMH plans to utilize a consumer survey instrument to measure the quality of participation, in at least a significant sample of the population.

Significance: Collaboration between staff and parents and/or guardians concerning treatment of children is considered a "best practice."

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Objective I/5/3 C/A: Develop and implement services for clients who are deaf or hard of hearing.

Brief Name: *Deaf services*

Indicator: the percent of DMH clients who are deaf or hard of hearing receiving appropriate services and communication access

Measure: # of DMH clients who are deaf or hard of hearing assigned to deaf-sensitive services, including appropriate communication access
# of DMH clients who are deaf or hard of hearing

Year 1: *60%* of DMH clients who are deaf or hard of hearing are assigned to community services with appropriate communication access

Year 2: *80%* of DMH clients who are deaf or hard of hearing are assigned to community services with appropriate communication access

Year 3: *90%* of DMH clients who are deaf or hard of hearing are assigned to community services with appropriate communication access

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/3. *Deaf services*					
Value: % C/A receiving deaf-sensitive services with communication access		**87.5%**	**60%**	**80%**	**90%**
Numerator: # of DMH clients receiving services with communication access		**14** (receiving a DMH service, but may lack appropriateco mmunca-tion access)			
Denominator: # of DMH clients who are deaf or hard of hearing	**20**	**16**			

Data Source: DMH Deaf Services Coordinator; DMH Data Warehouse (includes 5 of 6 DMH Areas and may include a stay in the deaf inpatient unit as well as community services).

Background: As described in previous sections, DMH has undertaken to centrally coordinate the provision of services to this special population. The coordinator, a social worker who is fluent in ASL and culturally competent in deafness, provides clinical oversight and consultation to the field. Although most deaf or hard of hearing clients receive DMH services, they may not be able to communicate optimally through use of TTY, interpreters, etc. A principal goal is to assign them to case managers and/or other community services that afford full communication access. Three new qualified social workers will be hired in SFY'05 and four new residential slots have been created. As funding becomes available, community services will be added or expanded.

Significance: Increasing access to services is a major goal of DMH.
++

Objective I/5/4 C/A: Provide access to trained staff, as necessary, to (families of) children and adolescents who contact Emergency Service Programs (ESP).

Brief Name: *Child/adolescent emergency services*

Indicator: the percent of C/As who contact an ESP and have access to a child-trained specialist

Measure: # of ESPs with child-trained staff / # of ESPs

Measure: # of C/As who receive child-specific emergency services / # of C/As who request assistance from ESPs

Year 1: ESPs are assessed for their capability to provide access to child-trained clinicians

Year 2: Recontracting process for the ESPs requires access to child-trained clinicians and monitoring of compliance with this expectation

Year 3: *100%* of ESPs have child-trained staff available; 100% of C/As receive child-specific emergency services

Performance Measures:	SFY'03 Actual	SFY'04 Projected	SFY'05 Goal	SFY'06 Goal	SFY'07 Goal
I/5/4. *C/A emergency services*					
Value: % C/As receiving child-specific emergency services			**Assess ESPs for capability**	**ESP recontract-ing includes C/A needs**	**100%**
Numerator: (a) # of ESPs with child-trained staff (b) # of C/As who receive child-specific emergency services					
Denominator: (a) # of ESPs (b) # of C/As who request ESP assistance					

Data Source: MBHP and DMH Southeastern Area

Background: Children and their families who contact ESPs for emergency assistance need to have access to clinicians who are specifically trained to meet their needs. ESPs are at the front door of the mental health system, particularly if hospitalization is required. A number of years ago, when MBHP took over contracting with the ESPs, DMH required them to have access to specialists in child and adolescent medicine and/or psychiatry to consult to ESP staff, when indicated. This capability will be assessed and if necessary, improvements will be made to ensure availability of specialized staff and/or consultants during the re-procurement process.

Significance: Access to services is a major goal of DMH.

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Population: Transition age youth with serious emotional disturbance

Objective I/5/5 C/A: Maintain or increase services targeted to transition age youth

Brief Name: *Transition age youth*

Indicator: **the percent of transition-age youth enrolled in supported housing, supported employment and case management programs**

Measure: # of 16-25 year old youth enrolled in supported housing, supported employment and case management programs
# of eligible 16-25 year old youth

Year 1: Maintain or increase the number of 16-25 year old youth enrolled in supported housing, supported employment and case management programs

Year 2: Maintain or increase the number of 16-25 year old youth enrolled in supported housing, supported employment and case management programs

Year 3: Maintain or increase the number of 16-25 year old youth enrolled in supported housing, supported employment and case management programs

Indicator: the number of transition aged youth enrolled in a youth leadership training program

Measure: # of 16-25 year old youth enrolled in a youth leadership training program

Year 1: *15* youth, aged 16-25, are enrolled in a youth leadership training program

Year 2: *17* youth, aged 16-25, are enrolled in a youth leadership training program

Year 3: *20* youth, aged 16-25, are enrolled in a youth leadership training program

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/5 *Transition age youth*					
Value: (a) % 16-25 year old youth in pilot Area enrolled in: supported housing: supported employment: case management:		**7.6%** **8.3%** **61.2%**	**7.6%** **8.3%** **61.2%**	**7.6%** **8.3%** **61.2%**	**7.6%** **8.3%** **61.2%**
Numerator: # 16-25 year old youth enrolled in supported housing: supported employment: case management:		**238** **260** **1,912**			
Denominator: # of eligible 16-25 year old youth		**3,125**			
Value: (b) # 16-25 year old youth enrolled in a youth leadership training program in pilot Area		**11**	**15**	**17**	**20**

Data Source: DMH Data Warehouse; DMH Area Reports

Background: Most young adults who have been served through the child-adolescent system aspire to independence. However, a key element of their being able to function independently is their ability to find appropriate housing, to acquire and sustain gainful employment and to develop other skills that will enhance their ability to live in the community. In order to further that goal, DMH has embarked on a pilot project to

provide these critical services to youth ages 16-25. In addition, case managers have been assigned specifically to work with this age group. The pilot program is part of a Strategic Plan for Transition Age Youth in the DMH North East Area. If funding is available, services will be increased to reach additional youth. There is also another very successful program that provides educational and vocational supports to transition-age youth in the Metro Suburban Area in which the specific supports and services are tailored to each individual's needs and goals.

The Youth Leadership training program works with adolescents in the North East Area to help them articulate their relationships to treaters, that is case managers, doctors, clinicians; to understand their medications and side effects, to support and assist them in developing skills needed for independent living. Youth have expressed interest in exploring job searching techniques, resume writing, interviewing skills, housing search techniques, social skills and budgeting.

Significance: Increasing independence and community tenure for young adults transitioning from the child-adolescent service system is an important DMH goal.
++

Objective I/5/6 C/A: Support community efforts to identify and refer children and adolescents with mental health problems for appropriate care and treatment.

Brief Name: *Identification and referral*

Indicator: Pediatricians gain access to child psychiatric consultation for patients with behavioral health issues.

Measure: Number of pediatric or family practices participating in the consultation and referral program

Year 1: Develop a plan to build on the UMass Medical School pilot that provides timely child psychiatric consultation to pediatric or family practices; 50 practices will be enrolled in the Massachusetts Child Psychiatry Access Project.

Year 2: *200* pediatric or family practices will be enrolled in the program to access consultation from the Massachusetts Child Psychiatry Access Project

Year 3: *400* pediatric or family practices will be enrolled in the program to access consultation from the Massachusetts Child Psychiatry Access Project

Performance Measures:	**SFY'03 Actual**	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/6. *Identification & Referral*					
Value: # pediatric & family practices enrolled in the Massachusetts Child Psychiatry Access Project	**N/A**	**N/A**	**50**	**200**	**400**

Data Source: MBHP Database

Background: Most children with behavioral health problems receive care from their primary care physician. Based on the success of a pilot program at the UMass Medical School whereby pediatricians and family practitioners have access to immediate telephone consultation and, if necessary, referral to a group of child psychiatrists, EOHHS is funding a project to replicate the program across the state, managed by MBHP.

The Massachusetts Child Psychiatry Access Project is designed to stretch existing child psychiatry resources by supporting community pediatricians and family practitioners in handling the more routine behavioral medicine issues and medications, by giving them direct access to and consultation from board certified child psychiatrists in their regions. Each region will have a full-time child psychiatrist, social worker, and case manager to work with pediatric and family practices to support them, consult with them around their cases, and provide second opinions when indicated. They also will assist them in accessing community resources and making referrals.

MBHP will collect data on pediatric and family practices enrolled by each regional site in the program, encounters from these practices, unduplicated members served, and actual face-to-face visits provided by the psychiatrist, social worker or case manager.

Significance: Access to child psychiatric consultation will help pediatricians and family practitioners provide more appropriate behavioral health care to children and families, either directly or by referral.

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Objective I/5/7 C/A: Survey youth and families to assess whether DMH services result in improved outcomes

Brief Name: *Consumer Satisfaction*

Indicator: the percent of youth and families who report improvement in symptoms, functioning and/or quality of life as a result of receiving DMH services

Measure: # youth who report improvements in their symptoms, functioning and/or quality of life / # youth surveyed

Measure: # families who report improvements in their children's symptoms, functioning and/or quality of life / # families who respond to survey

Year 1: Conduct research to select a tool and methodology for carrying out a statewide consumer satisfaction survey

Year 2: Based on recommendations of research group, select a tool and methodology and begin data collection and analysis based on completed pilot survey

Year 3: Conduct full survey and analyze results

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
I/5/7. *Consumer Satisfaction*					
Value: the % of youth who report improvements in symptoms, functioning and/or quality of life as a result of receiving DMH services	**N/A**	**N/A**	**Select tool and methodology**	**Pilot survey; collect and analyze data**	**TBD**
Numerator: # of youth surveyed, who report improvements	**N/A**	**N/A**			
Denominator: # of youth surveyed	**N/A**	**N/A**			
Value: the % of families who report improvements in their child's symptoms, functioning and/or quality of life as a result of receiving DMH services	**N/A**	**N/A**	**Select tool and methodology**	**Pilot survey; collect and analyze data**	**TBD**
Numerator: # of families surveyed, who report improvements	**N/A**	**N/A**			
Denominator: # of families surveyed	**N/A**	**N/A**			

Data Source: Consumer Quality Initiatives, Inc.; DMH Div. of Mental Health Services

Background: For a number of years, DMH has contracted with Consumer Quality Initiatives, Inc. (CQI), a Boston-based consumer-run organization, to conduct consumer satisfaction surveys in some of its programs. Included were adult DMH inpatient, case management, residential and PACT programs, to name a few. These surveys, which are conducted via face-to-face interviews, have been well received. In addition, every child and adolescent program that contracts with DMH is required to survey its own service recipients to assess satisfaction with the program. Programs report the results annually to DMH through Performance Based Contracting (PBC) and the results are compiled in the PBC database. However, the PBC program-based surveys have never been tested for validity and reliability.

In order to collect satisfaction and outcome data for the block grant and for the Uniform Reporting System Table 11, DMH will begin, in SFY'05, to develop a more comprehensive plan for conducting a statewide consumer survey, using a tool that has been tested and proven reliable. We will use the first year to research the tools and methodologies available for conducting this kind of survey. The survey will be piloted during Year 2 and fully implemented during Year 3. It is anticipated that the results of the survey will be used to inform program development and service delivery. Youth and their families will be invited to participate in the survey.

CRITERION II: Mental Health System Data Epidemiology

Quantitative population targets to be achieved through the implementation of the mental health system, including estimates of the numbers of individuals with serious mental illness (SMI) or serious emotional disturbance (SED) in the state (prevalence rates) and the numbers of such individuals served.

Identification and Analysis of the Service System's Strengths, Needs and Priorities

Criterion II: Issues Common to Adults, Children and Adolescents

Federal Definitions

Although all of the Department's eligible clients meet the criteria established in the federal definition of "serious mental illness" or "serious emotional disturbance," the target population - people with serious mental illness or serious emotional disturbance with severe dysfunction or substantial functional impairment and in need of publicly funded mental health services - represents only a small subset of the population covered by the definitions. For example: DMH is a provider of continuing rather than acute care, therefore a DMH client is defined as someone receiving continuing care services. Furthermore, children with mental health problems may be receiving mental health services from another public agency, including local education authorities, or through private insurance or Medicaid. Also, individuals in Massachusetts with particular diagnoses that are included in the federal definitions, such as people with Alzheimer's disease, those with primary substance abuse disorders, and children aged 0-3, do not fall under the statutory responsibility of DMH. They receive services through DPH. However, any individual dually diagnosed with mental illness and substance abuse disorder is eligible for DMH continuing care community services.

With the recent transfer of the Medicaid Behavioral Health Program (mental illness and substance abuse) to DMH authority, part of the integration planning will have to address the issue of tracking individuals who meet the DMH criteria and those who do not, although they may very well meet the federal definitions of mental illness or serious emotional disturbance.

DMH will continue to depart from the federal definition and consider children from 0 through 18 as its child/adolescent population. This has been the operative definition in Massachusetts since 1988.

Data Systems

DMH is close to full implementation of its new Mental Health Information System (MHIS). As previously reported, this is a multi-faceted system that has applications in both hospitals (administrative systems and an electronic medical record) and the community (care management). Phase II, the care management system, is now being implemented in the last DMH Area and all information will be accessible from the DMH Data Warehouse by the end of September 2004. The ability to capture information about all of the services received by a DMH client will be greatly enhanced, with the

caveat that DMH must still develop an effective way of entering data for non case managed clients. Phase III, the electronic medical record, is implemented in all of the hospitals and will be implemented in the remaining CMHCs within several months. In SFY'06 and '07, Meditech (the software developer) will provide technical software upgrades and DMH users will be trained in their use and a modification will be made to the Care Manager module (Phase II) to allow for ISP linkage and availability of ISP information in MHIS. Finally, MHIS will be synchronized with the data systems at the two DPH hospitals with DMH inpatient units.

The expectation is that MHIS will improve client care and quality management, and also generate reports that enable managers to gauge program effectiveness. There are plans to fine-tune the applications to meet specific program and service needs and block grant reporting. The primary goal of MHIS is to help DMH answer the following four questions:

- Who is receiving DMH services?
- What services are being provided?
- How much do the services cost?
- What are the outcomes/are the services effective?

In addition to MHIS, other division-specific data tracking systems exist for Investigations, Contracting, Child and Adolescent Statewide programs, Housing, Employment and Seclusion and Restraint.

All of the Department's systems incorporate safeguards regarding client confidentiality, with access granted strictly on a need-to-know basis. On July 17, 1998, the Commissioner signed a DMH "Security and Confidentiality Policy for DMH Computerized Information Systems Containing Client Records or Data" to further ensure that strict standards were in place before MHIS was implemented. In addition, HIPAA regulations regarding privacy of client information became effective in October 2003.

Service Issues and Gaps

Although a full continuum of care exists within the state, there is not a sufficient quantity of services in each DMH service Area, especially case management and residential services. Local planning processes identify service gaps and any new dollars are distributed in such a way as to meet the needs and correct historical funding inequities. In SFY'01, DMH used a new model of estimating prevalence for children with serious emotional disturbance, developed jointly with researchers from the UMass Center for Excellence (a DMH-funded research center). It undertook a similar project to estimate prevalence for adults, based on the 2000 census data. These estimates are used to allocate any new resources.

DMH is continuing to improve the availability of specialized services to meet the needs of individuals between the ages of 16 and 25, including those who meet the criteria for adult services and those who do not meet these criteria but are not able to live independently. Also, the needs of adults and children with mental retardation and/or developmental disabilities, including autism spectrum disorders, and severe psychiatric symptoms are not well met. DMR has been assigned responsibility for autism spectrum disorders, previously unassigned to any agency. Also, DMH continues to work actively with the Department of Public Health to address the needs of those clients with co-occurring MH/SA disorders, to address the deficiencies in services for this population.

DMH is including two separate indicators under this Criterion to track service capacity. **Objective II/1/1** (Adult and Child/Adolescent) reports on the *unduplicated* number of clients who receive at least one *community* service from DMH each fiscal year. All of these individuals meet the federal definitions for Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED). In addition, there are charts that include separate, unduplicated numbers of individuals (adults, elders and children) who receive DMH inpatient, residential and case management services (note: residential and case management also are included, but not specifically broken out, in Objective II/1/1).

Objective II/3 (Adult and Child/Adolescent) is **Table 2A**, which tracks all services (*unduplicated, community and inpatient*) provided to all individuals receiving services funded by DMH, distributed by age, gender and ethnicity, and includes both those who are SMI or SED and those who are not (some forensic patients). **Tables 14A & B,** which ask for the same information but are restricted to those individuals who meet the SMI or SED definitions, are not included at this time because DMH is not able to accurately identify, in its data system, forensically involved individuals who receive inpatient services at DMH hospitals but do not meet the SMI or SED definition. In the future, when our ability to accurately identify them improves, we will complete **Tables 14A & B** and include it in the Plan and Implementation Report**.**

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Criterion II: Issues Pertinent to Adults

Methodology (Prevalence Estimates)

Since 1990, the Massachusetts Department of Mental Health has based its prevalence estimates for adults (age 19+) on its own NIMH-funded study. Prevalence was based on three separate categories: adults with a diagnosable mental illness (15.22%); adults with a diagnosable mental illness and accompanying dysfunction in one of the four basic functional domains (5.34%); and adults with a diagnosable mental illness with dysfunction in basic self care (.98%).

With the publication of a new prevalence estimation methodology for adults by the Center for Mental Health Services in March 1997, the Department changed the first two categories to match the CMHS definitions:

- prevalence of serious mental illness in Massachusetts – *5.7* percent
- prevalence of serious and persistent mental illness in Massachusetts – *2.6* percent

DMH will continue to use the third category – adults with serious and persistent mental illness and severe dysfunction in basic self-care (.98%) – to define its target population. DMH has updated its adult prevalence estimates using 2000 census data. Calculations for the last column (.98%) have been weighted to reflect two variables, poverty and percentage of divorced males, both of which have been determined in research studies to accurately predict the prevalence of serious mental illness in the adult population.

Prevalence Estimates for Adults (2000 census)

DMH Area	Adults with Serious Mental Illness (5.7%)	Adults with Serious and Persistent Mental Illness (2.6%)	Adults with Serious & Persistent Mental Illness and Severe Dysfunction* (.98%) (weighted)
Western Mass	35,004	15,967	**6,024**
Central Mass	32,894	15,004	**5,650**
North East	53,371	24,344	**9,173**
Metro Boston	41,966	19,142	**7,236**
Metro Suburban	55,876	25,487	**9,592**
Southeastern Mass	52,413	23,908	**9,008**
Total	**271,524**	**123,853**	**46,683**

* Severely disabled adults, unable to provide for basic self-care. DMH estimates approximately half will seek or use public mental health services at any given time (the target population). Despite long waiting lists for high demand or high intensity services such as case management, PACT and residential services, most adults who apply and meet the DMH eligibility criteria receive at least one less intensive community service while waiting. Alternatively, they are admitted, if they meet the clinical criteria, to DMH continuing care inpatient services.

The charts below present information regarding the unduplicated number of adult and elderly DMH clients who received case management, inpatient (DMH-operated and contracted hospitals) and residential services in SFY'03. The performance targets in this three-year Plan (2005-2007) use SFY'03 as the baseline year for comparison.

An Unduplicated Count of Adult Clients Served by DMH in SFY'03

DMH Area	# Eligible	Case Management	Inpatient*	Resid/Rehab/Option
Metro Boston	5,773	1,475	481	2,069
North East	3,261	2,406	326	1,262
Southeastern	2,702	2,055	867	1,555
Metro Suburban	2,983	1,603	453	1,290
Central Mass.	2,010	1,190	201	736
Western Mass.	2,935	1,602	156	1,160
Total	**19,664**	**10,331**	**2,484**	**8,072**

* includes forensic and non-forensic admissions to all state hospitals, CMHCs and DMH units in public health hospitals, and one contracted unit as well as contracted forensic beds in the Western Mass. Area.

An Unduplicated Count of Elders (>65 years old) Served by DMH in SFY'03

DMH Area	# Eligible	Case Management	Inpatient*	Resid/Rehab/Option
Metro Boston	467	47	10	121
North East	123	51	8	40
Southeastern	153	85	23	59
Metro Suburban	153	47	13	47
Central Mass.	143	39	10	23
Western Mass.	289	88	4	67
Total	**1,328**	**357**	**68**	**357**

* includes forensic and non-forensic admissions to all state hospitals, CMHCs and DMH units in public health hospitals, and one contracted unit as well as contracted forensic beds in the Western Mass. Area.

As noted elsewhere, DMH provides primarily extended stay inpatient and continuing care community services, but very little acute care. In SFY'03, MBHP (DMA's behavioral managed care vendor) provided mental health services for *82,590* adults, some of whom met the criteria as established by the federal definitions, for serious mental illness.
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CRITERION II - ADULT PERFORMANCE INDICATORS

Goal II/1 A: Increase availability of community-based mental health services

Population: **Adults with serious mental illness**

Objective II/1-A: Increase the number of DMH clients who receive a continuing care community service.

Brief Name: *Service capacity*

Indicator: the percent of adults who receive a continuing care community mental health service

Measure: # of adults who received a DMH continuing care community service
adults eligible for DMH continuing care community services

Year 1: *87%* of eligible adult clients will receive at least one DMH community service.

Year 2: *87%* of eligible adult clients will receive at least one DMH community service.

Year 3: *87%* of eligible adult clients will receive at least one DMH community service.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
II/1 *Service capacity*					
Value: % adults who receive at least one continuing care community service	**97%**	**87.3%**	**87%**	**87%**	**87%**
Numerator: # of adults who received a DMH continuing care community service	**20,290**	**17,297**			
Denominator: # adults eligible for DMH continuing care community services	**20,992**	**19,806**			

Source of Information: DMH Data Warehouse

Background: DMH's enrolled population refers to those who apply for and are determined eligible for DMH continuing care community services, for whom no other options, outside of DMH, exist. DMH services include residential, PACT, case management, day, outpatient, educational and employment services, and other community services, such as community rehabilitation support. After being found eligible to receive DMH community services, each individual is assigned to services according to priority of need. If no appropriate community service is available, the individual is placed on a waiting list and is contacted on a regular basis regarding wait status. *Please note that the numerator above includes clients receiving PACT team services but not individuals receiving inpatient, outpatient or forensic services only, or Clubhouse members, if Clubhouse is the only service they use. DMH does not require adults solely participating in Clubhouse programs to apply for DMH eligibility and does not include them in its Client Tracking System, even though they are usually referred to the Clubhouse by DMH.*

Significance: Access to and availability of community mental health services is a goal of DMH.

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Objective II/2 A: Increase the number of DMH clients who receive evidence-based practices.

Brief Name: *Evidence-based practice*

Indicator: **the number of adults who receive an evidence-based practice**

Measure: # of adults who receive an evidence-based practice

Year 1: >5,000 DMH adult clients receive an evidence-based practice.

Year 2: >5,000 DMH adult clients receive an evidence-based practice.

Year 3: >5,000 DMH adult clients receive an evidence-based practice.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
II/2 *Evidence-based practices*					
Value: Evidence-based practices provided: (Y or N)					
1. Assertive Community Treatment	**Yes**	**Yes ***	**Yes**	**Yes**	**Yes**
2. Supported Employment	**Yes**	**Yes ***	**Yes**	**Yes**	**Yes**
3. Medication Algorithms	**No**	**No**			
4. Family Psycho-Education	**No**	**No**			
5. Integrated Tx: MH/SA	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
6. Illness Self Management	**No**	**No**			
Measure: # of DMH adult clients who receive an evidence-based practice (*ACT & Supp. Emp. only)		**5,357***	**5,357**	**5,357**	**5,357**

Data Source: DMH Data Warehouse

Background: Massachusetts has been funding, providing and/or supporting various treatment modalities for many years that subsequently have been determined to be within the realm of evidence-based practice. Outcome measurements have proved these interventions to be successful. As the criteria for determining if a practice is evidence-based have become more rigorous, and approved toolkits and guidelines have become available, Massachusetts is moving toward establishing these as mandated program standards.

The 13 DMH-funded and/or operated PACT teams are being monitored to assure fidelity to the PACT model. Integrated treatment of individuals with co-occurring disorders is a best practice and DMH is committed to this goal. DMH has a set of guidelines/principles to direct this treatment approach. Furthermore, it is an expectation in certain treatment settings (e.g., residential). The goal for the next three years is to review and update these guidelines, if necessary, to ensure they are current with evidence-based practices, and to improve coordination with DPH to increase programming for this population. However, there is no coding in our data system, currently, that can measure exactly who is receiving integrated treatment. Therefore, those people are not included in the chart above. The Commissioner's new authority over the Medicaid Behavioral Health Program and DMH's co-location with DPH in the EOHHS Health cluster bode well for improved coordination and integration of MH/SA services. Data recording also will be improved to reflect this treatment modality.

Significance: Use of evidence-based practices is a goal of DMH.
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Goal II/2 A: Implement a comprehensive, responsive and integrated mental health information system (MHIS).

Population: **Adults with serious mental illness**

Objective II/2-A: **Improve accuracy of demographic and forensic information**

Brief Name: *Mental Health Information System*

Indicator: **Demographic information in MHIS is accurate and complete**

Measure: Client records contain accurate information concerning age, gender, race and ethnicity

Year 1: A report is run on MHIS to determine current compliance rate of demographic information; the DMH service application is revised to improve likelihood of correct and complete data entry for race and ethnicity; training on demographic data entry requirements is provided to appropriate staff in all six DMH Areas.

Year 2: Complete demographic information is available for *95%* of all *applicants*; complete demographic information is available for *75%* of all *case managed clients* and *50%* of all non-case managed clients.

Year 3: Complete demographic information is available for *95%* of all *case managed clients* and *80%* of all *non-case managed clients*

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
II/1/2 A. *Mental Health Information System*					
Value/Measure: Client records contain accurate information concerning age, gender, race and ethnicity Applicants: Case managed: Non-case managed:			Baseline established; application revised; training provided	**95%** **75%** **50%**	**95%** **95%** **80%**

Data Source: DMH Data Warehouse

Background: MHIS is now operating in all DMH Areas, although the last phase of implementation of the care management module (community services) will not be fully implemented until the end of September, and the electronic medical record will not be complete until mid-2005. When MHIS is fully implemented, the next task will be to identify those data areas that are incomplete and devise remedies. One area identified for improvement is demographic information, specifically race and ethnicity. Having complete data in these fields will improve service planning and delivery. Standardized queries that can be utilized with the DMH Data Warehouse (INFORM) are being developed and will be used to pull most of the data needed for block grant and management reporting purposes.

Significance: Access to reliable information about DMH clients and community mental health services is a goal of DMH and essential to providing high quality care.
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Criterion II: Issues Pertinent to Children and Adolescents

Methodology (Prevalence Estimates)

In 2000, based on publication of a final estimation methodology by the Center for Mental Health Services in July 1998, DMH adjusted its estimate for children 9-18. This was updated in August 2002 to reflect 2000 census data. As previously noted, DMH will continue to depart from the federal definition and consider children from 0 through 18 as its child/adolescent population.

Based on Massachusetts' ranking in the middle tier of states in terms of number of children living in poverty, it is estimated that *seven* percent (children with serious emotional disturbance [SED] and *extreme* dysfunction) would need intensive mental health services. It is estimated that *eleven* percent (children with SED and *substantial* functional impairment) would meet DMH clinical eligibility criteria for less intensive community mental health services.

Researchers from the UMass Research Center of Excellence explored which, if any, variables particular to children and to Massachusetts need to be used to weight the six DMH Areas in estimating prevalence. Based on available data and research, they determined that the only reliable variable was poverty. The results of their work will continue to be used as a basis for distributing new budgetary resources for children and adolescents and form the basis for the prevalence data in the chart below. The chart includes the number of children in the DMH planning population, by Area. Since there are no current nationally accepted data available to estimate prevalence among children 0-8, DMH will continue to estimate that *2.5 percent* of severely disabled children in that cohort will need mental health services. In Massachusetts, there are many entities that fund and/or provide mental health services for children, including DMH, DMA, other child-serving state agencies, local education authorities and/or private insurance.

Prevalence Estimates for Children & Adolescents (2000 census)

DMH Area	Total Population 0-18	Total Population 0-8	Total Population 9-18	SED 9-18 with extreme dysfunction (7%)	SED 9-18 with substantial functional impairment (11%)	SED 0-8 in need of mental health services (2.5%)
Western	**213,153**	**92,336**	**120,817**	**8,457**	**13,290**	**2,308**
Central	**215,692**	**100,996**	**114,696**	**8,029**	**12,617**	**2,525**
North East	**327,824**	**155,984**	**171,840**	**12,029**	**18,902**	**3,900**
Metro Boston	**189,510**	**87,821**	**101,689**	**7,118**	**11,186**	**2,196**
Metro Suburban	**320,811**	**154,976**	**165,835**	**11,608**	**18,242**	**3,874**
South-eastern	**275,059**	**145,719**	**172,815**	**12,097**	**19,010**	**3,643**
Total	**1,585,524**	**737,832**	**847,692**	**59,338**	**93,246**	**18,446**

The total planning population of children and adolescents in Massachusetts (the sum of the last two columns) is *111,692*.

The charts below present information regarding the unduplicated number of child and adolescent DMH clients who received case management, inpatient (DMH-contracted hospitals) and residential services in SFY'03. The performance targets in this three-year Plan (2005-2007) use SFY'03 as the baseline year for comparison.

An Unduplicated Count of Child/Adolescent Clients Served by DMH in SFY'03

DMH Area	# Eligible	Case Management	Inpatient*	Residential**
Metro Boston	1,263	213	24	34
North East	488	475	33	180
Southeastern	648	431	53	69
Metro Suburban	334	237	27	89
Central Mass.	316	234	11	55
Western Mass.	530	385	18	330
Total	**3,579**	**1,975**	**166**	**757**

* Includes forensic and non-forensic admissions to the three statewide contracted extended stay adolescent units at Westborough and Taunton State Hospitals and one statewide extended stay latency age unit.

**Includes community residences and intensive residential treatment programs certified for Rehab Option and Psych Under 21 reimbursement

The figures in the chart represent only a small portion of children served by DMH and an even smaller portion of children receiving publicly funded mental health services in Massachusetts. DMH provides many more community services in addition to case management and residential services. In addition, as noted elsewhere, the responsibility for providing mental health services to children and adolescents with serious emotional disturbance (SED) is shared among many Massachusetts agencies and the private sector. For example, in SFY'03, MBHP (DMA's behavioral managed care vendor) provided mental health services for *44,560* children, some of whom met the criteria, as established by the federal definitions, for serious emotional disturbance.

CRITERION II - CHILD/ADOLESCENT PERFORMANCE INDICATORS

Goal II/1 C/A: Increase availability of community-based mental health services

Population: **Children and adolescents with serious emotional disturbance**

Objective II/1/1 C/A: Increase the number of DMH clients who receive continuing care community services.

Brief Name: *Service capacity*

Indicator: **the percent of children and adolescents who receive a continuing care community mental health service**

Measure: # of children who receive a DMH continuing care community service
# of children eligible for DMH continuing care community services

Year 1: *84%* of eligible children and adolescents will receive at least one DMH community service.

Year 2: *84%* of eligible children and adolescents will receive at least one DMH community service.

Year 3: *84%* of eligible children and adolescents will receive at least one DMH community service.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
II/1/1 C/A. *Service capacity*					
Value: % of eligible C/As who receive a continuing care community service	**88.2%***	**83.7%***	**84%**	**84%**	**84%**
Numerator: # of C/As who received a DMH continuing care community service	**3,156**	**2,949**			
Denominator: # of C/As eligible for DMH continuing care community services	**3,579**	**3,523**			

* Please note that in Massachusetts, the Department of Public Health is specifically mandated to provide services for children birth to three years old. As noted in this report, DMH is only one of a number of child-serving agencies in the state, including local education authorities and private insurance, that provide children and adolescents with mental health services.

Data Source: DMH Data Warehouse

Background: The numerator represents only the children for whom DMH provides services. These services include residential and/or case management and/or certain other

community services. Despite waiting lists for services such as case management and residential, most children or adolescents who meet DMH eligibility criteria receive at least one less intensive community service while waiting. *Please note that DMH does not include children solely receiving outpatient, short-term or school-based services, children receiving forensic evaluation services, children served by the two interagency projects, or the 4,000 families receiving help through parent support contracts in its Client Tracking System. DMH eligibility is not required for these services, therefore, they are not included in the numerator above.*

Significance: Access to and availability of community mental health services is a goal of DMH.

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Objective II/1/2 C/A: Increase the number of DMH clients who receive evidence-based practices.

Brief Name: *Evidence-based practice*

Indicator: **the number of children and adolescents who receive an evidence-based practice**

Measure: # of children who receive an evidence-based practice

Year 1: *37* children and adolescents with SED receive an evidence-based practice.

Year 2: *37* children and adolescents with SED receive an evidence-based practice.

Year 3: *37* children and adolescents with SED receive an evidence-based practice.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
II/1 C/A. *Evidence-based practice*					
Value: Evidence-based practices provided: (Y or N) Therapeutic foster care	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Numerator: # of children and adolescents with SED who receive an evidence-based practice		**37**	**37**	**37**	**37**

Data Source: DMH Data Warehouse

Background: Massachusetts has been funding, providing and/or supporting various treatment modalities for many years that subsequently have been determined to be within the realm of evidence-based practice. Outcome measurements have proved these interventions to be successful. As the criteria for determining if a practice is evidence-based have become more rigorous, and approved toolkits and guidelines have become

available, Massachusetts is moving toward establishing these as mandated program standards.

Therapeutic family care, as it is referred to by DMH, provides an alternative living situation for those children and adolescents who do not need the structure of a group care setting, but whose mental health issues have made them temporarily unable to remain in their own homes. Specially trained parents provide individualized therapeutic approaches, and children also may participate in individual, group or family therapy. These homes also may provide out-of-home respite for some children, but children receiving respite care only are not included in the above numbers.

Significance: Use of evidence-based practices is a goal of DMH.

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Goal II/2 C/A: Implement a comprehensive, responsive and integrated mental health information system (MHIS).

Population: **Children and adolescents with serious emotional disturbance**

Objective II/2-C/A: Improve accuracy of demographic information

Brief Name: *Mental Health Information System*

Indicator: Demographic information in MHIS is accurate and complete

Measure (a): Client records contain accurate information concerning age, gender, race and ethnicity

Year 1: Determine completeness of demographic information in MHIS; revise the DMH service application to improve likelihood of correct and complete data entry for race and ethnicity; provide training on demographic data entry requirements to staff in all six DMH Areas.

Year 2: Complete demographic information is available for *95%* of all *applicants*; complete demographic information is available for *75%* of all *case managed clients* and *50%* of all *non-case managed clients*

Year 3: Complete demographic information is available for *95%* of all *case managed clients* and *80%* of all *non-case managed clients*

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
II/2. *Mental Health Information System*					
Value/Measure: Client records contain accurate information concerning age, gender, race and ethnicity Applicants: Case managed: Non-case managed:			**Establish baseline; revise applica-tion;pro-vide training**	**95%** **75%** **50%**	**95%** **95%** **80%**

Data Source: DMH Data Warehouse

Background: MHIS is now operating in all DMH Areas, although the last phase of implementation of the electronic medical record will not be complete until mid-2005. When MHIS is fully implemented, the next task is to identify those data areas that are incomplete and devise remedies. One area identified for improvement is demographic information, specifically race and ethnicity. Having complete data in these fields will improve service planning and delivery. Standardized queries that can be utilized with the DMH Data Warehouse (INFORM) are being developed and will be used to pull most of the data needed for block grant and management reporting purposes.

Significance: Access to reliable information about DMH clients and community mental health services is a goal of DMH and essential to providing high quality care.
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Objective II/3 (Adult & C/A): Table 2A: Profile of Persons Served, All Programs by Age, Gender Race & Ethnicity in SFY'04

Objective II/2 (Adult & C/A): Table 2B: Profile of Persons Served, All Programs by Age, Gender Race & Ethnicity in SFY'04 (Persons who are Hispanic/Latino or not Hispanic/Latino)

CRITERION III: Children's Services

A statewide system of integrated social, educational, juvenile justice, and substance abuse services together with health and mental health services will be provided so that children with a serious emotional disturbance will receive care appropriate to their multiple needs (including services provided under the Individuals with Disabilities Education Act).

Identification and Analysis of the Service System's Strengths, Needs and Priorities

The Executive Office of Health and Human Services (EOHHS) is the responsible secretariat for the coordination of all children's services in Massachusetts. The agencies within EOHHS serving children exclusively are the Departments of Social Services (DSS), and Youth Services (DYS), and the Office of Child Care Services (OCCS). The Departments of Public Health (DPH), Mental Health (DMH), and Mental Retardation (DMR), the Divisions of Transitional Assistance (DTA) and Medical Assistance (DMA - Medicaid), and the Commissions for the Blind, and Deaf and Hard-of-Hearing, serve children and adults. The Department of Education (DOE) is not within EOHHS. DMH has primary responsibility for delivery of non-acute continuing care mental health services for those children with serious emotional disturbance (SED) who are not able to receive appropriate mental health services through other entities or through insurers. The six DMH Areas, 31 Local Service Sites and central office Division of Child/Adolescent Services are responsible for procuring, contracting for and monitoring all children's services. On interagency issues, EOHHS has taken the responsibility for coordinating, planning, and holding its constituent agencies accountable for results.

Several activities aimed at systemic reform and redesign are in process at the statewide level. In February, 2004, EOHHS launched the Behavioral Health Expansion Project, led by the DMH Commissioner, to assure that children and families served by DYS, DSS and DMR have their mental health needs promptly identified and addressed. DYS was the first focus. As a result of this activity, all children are now being screened for mental health problems and risk of self-harm before admission to a Boston-based DYS detention facility. Those in need of hospital-level of care are transferred. Also, additional clinical staff have been hired for this DYS detention facility. Suicide prevention training and procedures for monitoring at-risk clients and for periodic reassessment have been instituted across the entire DYS sytem. Protocols are being developed to assure that critical mental health information from hospitals, probation, the courts and DYS goes with the client as s/he moves through the juvenile justice system. Needs assessments and service development related to DSS and DMR will be conducted in SFY'05. This project has subsumed several initiatives aimed at pieces of service integration among these agencies.

The state agencies that serve children, providers, trade organizations and advocates also are actively involved with the EOHHS Suicide Prevention Task Force, targeted to reducing lethality, suicides and suicide attempts in programs providing 24-hour care to children and adolescents. This time-limited task force will make recommendations to the Secretary regarding facility safety, policies and procedures, training, crisis response and data collection.

Planning to create an integrated service system that can meet the behavioral health needs of all children and adolescents regardless of which agency is providing services continues under the aegis of the Children's Mental Health Commission, mandated by the legislature in its 2001-2002 session. The Commission, with a defined membership, including key agencies, parents and other advocates, physicians, provider organizations and professional groups is co-chaired by the Secretary of EOHHS and a physician, and has reached out to include an even broader array of representatives in its subcommittees. In addition to providing data regarding service utilization, wait list and access issues, which was its initial charge, the Commission will be making recommendations regarding service system integration, elements of system of care, short and long-term solutions to the so-called "stuck children" problem (children remaining in hospital level care after clinically ready for discharge), insurance and data collection. Their findings are expected to influence future state procurement of services for children and adolescents. The Department of Education, while not under the EOHHS umbrella, participates in this critical activity as well as in most other interagency efforts.

As a majority of children in the state have private insurance, that population must be considered as well. To do so, the Commission created a committee, co-chaired by the DMH Commissioner and the head of the state's Division of Insurance, to look at non-DMA populations (i.e., privately insured children) in an effort to shape the ways in which private health plans respond to children with mental health needs. Although recent legislation created parity in insurance coverage and an ombudsman resource at DPH to oversee managed care implementation, there had not previously been a formal mechanism by which the state could collect data about the privately insured, and advocate for reform.

DMH has been working since February 1999 with OCCS, DSS and DMA to develop training, consultation and treatment models for DSS-funded Supportive Child Care programs. A separate committee, co-chaired by DMH and DPH, has examined the needs for training, access to treatment, and consultation as they relate to the mental health needs of all child care providers serving children ages zero to six. The Governor’s School Readiness Commission, created in SFY ’01, also discussed this need, and recommended early screening to identify emotional and behavior health needs in its final report in November 2001. An outcome of this report is the establishment of school-readiness indicators. DMA and OCCS, which licenses all childcare programs in the state, have funded clinical positions, based in community clinics selected by childcare programs, to provide consultation, training and triage for children with behavioral problems. Many of these children exhibit symptoms of Post-Traumatic Stress Disorder or other early traumas. As the state creates a new Office of Early Education as mandated in the most recent legislative session, DMH will continue to advocate for services and structures to ensure that children with behavioral health issues have access to services and receive appropriate supports.

Providing integrated mental health and substance abuse services is a priority for DMH. DMH will be updating its guidelines in this area and supporting implementation of evidence-based practices within its own system. At the same time, DMH and PAL, the parent organization, are participating in DPH-led activities to develop a strategic plan for adolescents with substance use disorders to assure that youth with co-occurring disorders are able to access appropriate, comprehensive treatment.

Along with these policy and planning efforts which aim to institutionalize best practices across the state, including integrated service delivery, direct service initiatives

addressing integrated service delivery continue to flourish and expand. DMH, in partnership with the University of Massachusetts Medical School, was awarded a five-year SAMHSA Child Mental Health Initiative Grant in September 1999. Worcester Communities of Care (WCC) has as its goal the establishment of a system of care for children ages 6 through 18 and their families in the city of Worcester. The legislature provided state matching funds through EOHHS, and the Worcester Public Schools have provided the match since SFY'03. A local interagency steering committee and family advisory committee oversee the work of the project. WCC employs a wraparound approach to services and assigns a care coordinator to each family to arrange for services and assure that they are integrated and clinically coherent. WCC served *30* children in FY'01, its first year, and *75* children in SFY'04, and became a Comprehensive Family-Focused Care (CFFC) site in July 2003. Application has been made to SAMHSA to extend this program to 65 other communities in central Massachusetts.

The Mental Health Service Program for Youth (MHSPY), a Robert Wood Johnson Foundation system of care replication project based in a Health Maintenance Organization, has been serving children since March 1998. In SFY'02, MHSPY recouped funds from enrollment and cost reconciliation with its contractor, allowing it to expand capacity from *30* children at a time in Cambridge and Somerville to *50* children at a time in four cities. The planned expansion to the second site, encompassing the cities of Malden and Everett, occurred during SFY'02. MHSPY served *82* children in SFY'04. Both MHSPY and WCC continue to demonstrate success in prevention of out-of-home placement.

In July 2003, building on the successes of MHSPY and WCC, the Commonwealth introduced CFFC, a new integrated community mental health initiative for children and families in five designated sites across the state. Through the CFFC program, agencies are blending funds to provide children and families with family-focused, strength-based integrated care planning and intensive community-based mental health services to *250* children and families predicated on systems of care and wraparound principles. Worcester Communities of Care was chosen as a CFFC site, and it has been able share its expertise with others while it creates a stable source of ongoing funding for itself. DMA, the state's Medicaid agency, is the lead agency, and MBHP, its mental health and substance abuse managed care vendor, is providing administrative oversight. Other principal state agencies, including DMH and DOE, provide funding for CFFC, based on an agreed upon case rate. DMA, with interagency support, received a grant from the Center for Health Care Strategies, a Robert Wood Johnson affiliate, to provide training for and evaluation of the project. Measures of success for CFFC include: improved child functioning; improved family functioning; increased community tenure; improved school attendance and performance; reduced involvement with juvenile justice; and caregiver and child satisfaction.

The Collaborative Assessment Program (CAP) is an ongoing DMH-DSS project that provides a single point of entry to state services for families not previously involved with DSS or DMH who have a child with serious emotional disturbance (SED) who is at-risk of out-of-home placement. CAP offers intensive wraparound services and short-term placement if necessary to stabilize the immediate situation, and links parents with other parents who have had experience raising children with SED in the community. DMA contributes funding for wraparound services to Medicaid clients served by CAP. Jointly developed operational standards, joint DSS-DMH supervision of the CAP director, and ongoing training assure uniformity in program operations and data. PAL conducts the

training for the parent partners. The latest evaluation data show that the CAP has been successful in preventing out-of-home placements.

The need to assist youth in the transition from DMH child and adolescent services to the adult system, or to life in the community without DMH services has been recognized. A Youth Development Committee, including professionals, parents and youth, was established as a subcommittee of the State Mental Health Planning Council a few years ago to involve adolescents and young adults in service design and delivery of those services to its age group. As a result of the focus on transition, DMH has contracted with M*Power, a consumer-run organization, to hire and train peer mentors for adolescents transitioning into the adult mental health system, and has applied for federal funds to serve transition-age youth. In addition, the North East Area has developed a Youth Leadership Program, and several areas are experimenting with designating specific case managers to work with the transition-age population. DMH also participates in a statewide Youth Development Advisory Council staffed by EOHHS that also includes representatives from DSS, DYS, Probation, provider agencies and older adolescents focused on services to transition-age youth. The Council is linking youth with work training programs, and was able to secure tuition-free access to state universities for youth in foster care until budget cuts forced termination of this program.

School children of all ages continue to be a major focus. DMH is a member of the Statewide Advisory Committee on Special Education and the Advisory Committee for the state's Performance Improvement Grant. In SFY'04, DMH staff reviewed documents developed by an advocacy organization to give guidance to parents of children with special needs who fail to pass the standardized tests required for graduation.

The Parent Professional Advocacy League, PAL, the major advocacy organization for children's mental health, is actively involved in initiatives within the interagency community and with legal advocates, physicians, hospitals and providers. PAL has provided training for CFFC as well as for DMH and DSS providers on how to work collaboratively with parents. PAL serves on the CFFC Steering Committee, the Substance Abuse Strategic Planning Committee, the Children's Mental Health Commission, the statewide Special Education Advisory Committee, and co-chairs the Family Advisory Committee for Medicaid. PAL also works collaboratively with other children's advocacy organizations such as Adoptive Families Together. PAL operates the PRN line, a toll-free telephone line funded by the state's major insurers, to assist parents, youth and others to access services from state agencies, insurance, and through special education. PAL works closely with the media to highlight children's mental health issues and continues to educate the legislature about the need for increased funding of child/adolescent mental health services and about children's mental health issues and the impact of those problems on their families.

Restraint and Seclusion Reduction Initiative

As a result of this initiative, the use of restraint and seclusion for children and adolescents in acute and continuing care inpatient settings and intensive residential treatment programs in Massachusetts has declined significantly. Since the beginning of 2001, the DMH Licensing and Child/Adolescent divisions have been actively promoting strength-based interventions, through the Department's licensing and contracting authority, to reduce the utilization of these high-risk interventions. DMH collects statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient facilities (adults, children and adolescents) and intensive residential

treatment programs (children and adolescents). Review of restraint data from each facility and program and a discussion of prevention, early intervention and pro-active planning efforts are a focus of each two-year licensing visit and the more frequent monitoring visits and consultations.

A combination of conferences, grand rounds, clinical consultation and technical assistance on state-of-the-art practices has produced rates of reduction in the child and adolescent units and programs, the particular focus of these activities. Leadership changes in some of the units and new reporting guidelines from the Center for Medicaid and Medicare Services have produced some slippage in reduction rates in some facilities that will continue to be addressed through ongoing consultation and technical assistance. A similar initiative, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), was launched in 2003 by NTAC, the technical assistance arm of the National Association of State Mental Health Program Directors, for state hospitals (adult and child) nationwide. DMH licensing, data and child/adolescent staff were asked to provide some of the training. Two (adult) state hospitals in Massachusetts are participating in this initiative.

Service Issues and Gaps

Although there are several excellent service integration projects, these are mostly pilot projects serving narrowly defined populations in specific geographic areas. The challenge is to sustain existing projects, replicate these services statewide, and make them available for all children with multiple and complex needs, regardless of insurance status. Also, until contracts for the entire child and adolescent service system are re-procured, with common providers operating under common standards, each agency is operating on its own, which can present major challenges for families. The state currently has no formal mechanism for resolving disputes among human service agencies. To address this need, a proposal for regional Planning and Review Teams has been drafted and various focus groups have been organized to solicit feedback from stakeholders. The PRTs are being created to provide an administrative mechanism for resolution of challenges presented by complex cases, including issues of responsibility for service delivery and funding. They also will provide a means for collecting information in an organized way about the barriers to service integration, and will facilitate resolution of those problems.

CRITERION III: CHILD/ADOLESCENT PERFORMANCE INDICATORS

Goal III/1 C/A: Collaborate with other state agencies to provide children and adolescents with appropriate behavioral health services

Population: Children and adolescents with serious emotional disturbance

Objective III/1 C/A: Provide coordinated care to children whose needs require interventions under the jurisdiction of more than one child-serving agency

1(a) Brief Name: *Collaborative Assessment Program*

Indicator: the percent of children and adolescents served for whom out-of-home placement is avoided

Measure: # of C/A served by the CAP still living at home at the six month follow-up
# of C/A served by CAP

Year 1: *65%* of C/A served by the CAP program are still living at home at the six-month follow-up

Year 2: *65%* of C/A served by the CAP program are still living at home at the six-month follow-up

Year 3: *65%* of C/A served by the CAP program are still living at home at the six-month follow-up

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
III/1(a) C-A. *Collaborative Assessment Program*					
Value: % of families served by CAP for whom out-of-home placement is avoided at 6-month follow-up	**69%**	**70%**	**65%**	**65%**	**65%**
Numerator: # of children & adolescents served by the CAP who are still living at home at the six month follow-up	**154**	**143**			
Denominator: # of children & adolescents served by CAP	**223**	**204**			

Data Source: DSS-CAP data system

Background: The Collaborative Assessment Program (CAP) is a DMH/DSS program that was implemented statewide in SFY'99. The program aims to provide comprehensive assessments and flexible, short-term interventions for children at-risk for out-of-home placement. If state agency services are required, CAP determines the lead agency. The intent is to keep the child at home when appropriate and to provide services in the least restrictive way.

Significance: Maintaining children in their natural environment, unless contraindicated, is considered best practice and is a primary goal of the mental health block grant.
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1(b) Brief Name: *Interagency care coordination*

Indicator: the number of children and adolescents receiving interagency care coordination

Measure: # of children & adolescents enrolled in the MHSPY and WCC programs in SFY'03 (baseline)

Year 1: *170* C&A receive interagency care coordination through MHSPY & WCC

Year 2: *170* C&A receive interagency care coordination through MHSPY & WCC

Year 3: *170* C&A receive interagency care coordination through MHSPY & WCC

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
III/1(b) C-A. *Interagency care coordination*					
Value: the # of children and adolescents receiving interagency care coordination	**153**	**157**	**170**	**170**	**170**
Measure: # of children & adolescents enrolled in the MHSPY & WCC programs in SFY'03 (baseline)	**153**	**153**	**153**	**153**	**153**

Data Source: MHSPY and WCC tracking systems

Background: The Mental Health Service Program for Youth (MHSPY), a Robert Wood Johnson Foundation replication project, and Worcester Communities of Care (WCC), funded in part through a Child Mental Health Initiative grant from the Center for Mental Health Services, are interagency projects aimed at keeping children in their communities. The programs provide intensive wraparound services and clinical care coordination.

MHSPY is a state-funded program that serves children who are Medicaid clients from the communities of Cambridge, Somerville, Malden and Everett and enrolled in the Neighborhood Health Plan HMO. WCC uses both state and federal funds to serve Medicaid and non-Medicaid families of children at risk of out-of-home placement in the city of Worcester.

Significance: Maintaining children in their natural environment, unless contraindicated, is considered best practice and is a primary goal of the mental health block grant.
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III/1(c) Brief Name: *Parents with mental illness*

Indicator: DMH collaborates with the Department of Social Services to address the needs of parents with mental illness in the child welfare system

Measure: # of parents with mental illness who are involved with DSS for whom DMH provides short-term direct services or advice to DSS

Year 1: Develop a plan, protocols and data collection mechanism in each DMH Area to meet the needs of this population

Year 2: *200* parents will be served

Year 3: *200* parents will be served

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
III/1(c) *Parents with Mental Illness*					
Value/Measure: # of target population served			**Develop plan**	**200**	**200**

Data Source: DMH/DSS Area reports.

Background: DMH and DSS have been involved in joint planning concerning this population. Each DMH/DSS Area is developing its own protocols related to providing advice regarding families with parental mental illness and is planning joint agency trainings to foster collaborative work on this issue.

Significance: Providing appropriate mental health services is essential to maintaining children and their families in the community.
++

Goal III/2 C/A: Change the culture and improve staff-client interaction in DMH-licensed and contracted programs and facilities to reduce the need for mechanical and chemical restraint

Population: Children and adolescents with serious emotional disturbance in inpatient facilities and intensive residential treatment programs (IRTPs)

Objective III/2 C-A: Reduce incidents of restraint and seclusion in child-adolescent treatment settings

Brief Name: *Restraint Reduction*

Indicator: the number of reported incidents of restraint (per 1,000 patient days) in inpatient facilities and intensive residential treatment programs

Measure: the # of reported incidents of restraint in DMH-licensed and contracted inpatient facilities and intensive residential treatment programs (IRTPs)

Year 1: Work with facilities to implement & report uniformly on new CMS definitions; establish baseline (January-June SFY'05 data)

Year 2: Reduce the rate of restraint by *20%* (over baseline)

Year 3: Reduce the rate of restraint by *20%* (over SFY'06)

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
III/2 C/A. *Restraint Reduction*					
Value: the # of reported incidents of restraint (per 1,000 patient days) in inpatient facilities and IRTPs			**Uniform reporting; establish baseline**	**20% decrease**	**20% decrease**
Number of reported incidents of restraint (per 1,000 patient days) in DMH-licensed and contracted inpatient units and IRTPs*					
DMH-licensed units					
Children					
Adolescents	**27.79**	**30.72**			
Mixed C/A	**42.71**	**36.27**			
	16.14	**21.91**			
DMH-contracted inpatient units					
Adolescents	**41.38**	**97.26**			
DMH-contracted IRTPs					
Children					
Adolescents	**62.92**	**47.36**			
	23.97	**29.07**			

*These data do not consistently conform to the new CMS definitions of restraint

Data Source: DMH Licensing Division, Seclusion and Restraint Database

Background: The DMH collects monthly statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient units and IRTPs. DMH provides direction, technical assistance and clinical expertise designed to reduce the utilization of these high-risk interventions. Review of the unit's or program's restraint data and a discussion of prevention, early intervention and pro-active planning efforts have been a focus of each two-year licensing visit and more frequent contract monitoring visits. Through the Department's Restraint Reduction Initiative (RRI), staff in the licensing and child/adolescent divisions provide ongoing consultation and technical assistance to the Department's licensed and contracted inpatient units and intensive residential treatment programs to help them reduce the need for use of restraint and seclusion. Revised DMH restraint/seclusion regulations, which will focus heavily on prevention of restraint, are expected to have an impact on reducing restraint occurrences once developed and promulgated.

During SFY'03, the Center for Medicaid and Medicare Services (CMS) changed the standards defining physical restraint to include actions not previously defined or counted as restraints. The number of episodes of restraint was noted to have increased in the licensee hospital child and adolescent units in SFY'04. This increase may be partly attributed to the change in the CMS standards defining physical restraint. DMH is working with its licensee hospitals and IRTPs to assure conformance to the new guidelines and uniformity in reporting. Beginning in January 2005, all units will provide accurate and uniform data to DMH. The period January – June 2005 will therefore become the baseline for future comparisons.

Other DMH indicators, which include the number of hours per episode, the number of individuals restrained, and the use of mechanical restraint have not been affected adversely by the CMS changes.

Significance: Reducing the use of restraint and seclusion in facilities and programs that serve children and adolescents is a goal of the Department of Mental Health.

CRITERION IV: Targeted Services to Rural and Homeless Populations

Identification and Analysis of the Service System's Strengths, Needs and Priorities

Criterion IV: Issues Common to Adults, Children and Adolescents

Homeless

DMH has not received a legislative increase to its homeless budget (about *$21.1* million) since SFY'02. Before that, the account had been increasing by $1-$2 million annually, thus allowing DMH to serve and house additional homeless individuals each fiscal year. The level-funded budgets have not supported expansion, but no clients have been dropped from the program either. DMH has adopted a "maintenance of effort" approach concerning placement of homeless individuals and is striving to maintain the existing rate of service for this program. Other programs for homeless individuals with mental illness include PATH, which provides outreach and screening services to more than *5,000* people, housing efforts funded through the DMH Facilities Consolidation Fund, and Aggressive Treatment and Relapse Prevention (ATARP), which provides housing/services for homeless clients with a co-occurring mental illness and substance abuse disorder, and some of their families, including children. ATARP is funded by a $1.9 million renewal grant from HUD, with additional support from DMH ($525,000) and DPH ($500,000).

Massachusetts operates a comprehensive program of outreach, primarily to shelters, through the PATH grant, to individuals with mental illness who are homeless. This grant funds clinical social workers to go into adult shelters and identify people with serious mental illness. They provide direct care, housing advocacy and assistance, referrals for job training, literacy education, mental health services and substance abuse treatment, as well as referrals to other programs that provide benefits and entitlements. They also refer adults and older adolescents in need of mental health services to DMH if they meet eligibility criteria for DMH continuing care community services, or to other agencies for acute services, specialized services, entitlements, protective custody, etc. The program is augmented by a HUD grant and is coordinated with the state's homeless mentally ill initiative.

DMH continues to rely on a major study of homelessness in Massachusetts to guide its decisions on serving this population. The study, conducted by the Human Services Research Institute (HSRI) in Cambridge, Massachusetts, estimated that of the total number of homeless people in the Commonwealth (9,000), about *2,000-2,500* have a severe and persistent mental illness at any point in time. This estimate was calculated using nationally recognized and accepted prevalence estimates. Of the estimated number of people with mental illness who are homeless (HMI), most are found in urban settings, with about *1,000-1,250* in the Metro Boston Area and the remainder scattered throughout the state. It is estimated that *950-1,100* homeless individuals have a mental illness and co-occurring substance use disorder. Additional studies indicate that the homeless population is increasing and that the shelter system is operating beyond capacity. A report from UMass estimated that *28,800* individuals were served in the state's emergency shelter system in 2003, with elders among the fastest growing group.

Rural

The Department does not have a separate division or special policies for adults, children or adolescents who reside in less populated areas of the state. Each of the Department's 31 Sites has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the Sites has a population density below 100 people per square mile.

The primary goal of the Department's local planning process is to address the issue of access to services for all DMH clients. Each Site plan identifies target population, needs, available services and resources, gaps in services and resources, and barriers to implementation of a local service delivery system. Geographic distribution of the population is not an issue. Poverty of clients and lack of insurance are more significant variables since the lack of financial resources to pay for transportation interferes with the client's physical ability to get to where services are located and the lack of insurance limits availability. A particular focus relevant to rural populations continues to be access to transportation. At the Area level, many clients have identified this as a challenge. In child and adolescent service contracts, for example, transportation is one of the flexible supports often provided.

Service Needs and Gaps

There are a number of high-level task forces and work groups focused on reducing the problem of homelessness. DMH plans to be an active participant in many of these efforts and to ensure that these groups include the DMH population in their work plans and recommendations. The Massachusetts Interagency Council on Homelessness, chaired by the Lt. Governor, is specifically addressing the needs of homeless people with mental illness. An Interagency Committee on Chronic Homeless Services, a collaboration between DMH and the Department of Transitional Assistance (Welfare), is seeking to improve service delivery to the population of chronically homeless adults, particularly those with mental illness, substance abuse or co-occurring disorder. Key state agencies, homeless advocates and private service providers are being recruited for the committee.

An overarching goal of the mental health system is to strengthen existing discharge policies and procedures used by facilities and programs operated or licensed by DMH to reduce or mitigate homelessness.

Criterion IV: Issues Pertinent to Adults

Homeless

Since SFY'92, the DMH Homeless Initiative has enabled DMH to create a capacity for serving and placing an average of *2,400* homeless individuals with mental illness each year. DMH also has developed or gained access to more than *1,154* new units of housing. However, due to static funding, the capacity has not changed since SFY'02. The funds have provided a range of community-based services, such as first aid, counseling, and referral and case management for more than *11,000* homeless individuals.

In addition to the PATH program, there has been a steady increase in the numbers of HMI served by DMH housing initiatives. DMH homeless initiative funds are used primarily to provide clinical and residential services and to leverage federal and other resources to fund development of or access to housing units, such as PACT teams and contracted supported housing programs.

DMH also funds outreach programs to HMI individuals in transitional housing, shelters, on the streets and in less populated areas of the state. Members of outreach teams do active street work, ride in medical vans and visit emergency shelters. Physicians from affiliated agencies are available to provide medical care to homeless individuals who will not come in to a center or shelter for treatment. The Aggressive Street Outreach program serves individuals and families living in shelters or on the streets in Boston, Waltham, Lowell, Lawrence and Quincy. The program includes successful referrals to housing, detoxification and mental health services. A particularly innovative program and exemplary practice in Metro Boston - a collaboration between DMH and the Boston University School of Public Health called the Dudley Inn, under the Safe Haven Initiative – is the first of its kind that is being researched. It houses people with co-occurring disorder who have been homeless for a very long time and includes the services of a primary care physician at the site who meets regularly with residents.

From SFY'92 through the end of SFY'03, there also was *$15* million committed to new housing development from the DMH Facilities Consolidation Fund. This provided DMH with access to over *600* new housing units and leveraged about *$40* million in federal, state and private housing funds. It is estimated that *200* of these units went to people recovering from homelessness and mental illness.

In SFY'02, the PATH program was expanded in the Greater Boston, New Bedford, Taunton, and Holyoke Chicopee areas of the state. Under a statewide Homeless Initiative, a series of projects is in operation both in the Metro Boston Area and in areas outside of Boston.

There are several new planning initiatives designed to address the needs of DMH clients who are homeless or at risk of homelessness. These include: enhancing and expanding the Tenant Preservation Program; implementing the recommendations of the Homeless Policy Academy for a pilot group of chronically homeless individuals (in collaboration with the Department of Transitional Assistance; and maximizing very low income housing opportunities for DMH clients on surplus state mental hospital land. As these initiatives progress beyond the planning stage, new performance measures and indicators will be developed.

Shelters

The Department manages transitional residences (formerly shelters) for homeless individuals with mental illness (HMI) in the Metro Boston Area. These programs receive referrals from non-DMH shelters and are oriented towards stabilization and placement. Each program is affiliated with a DMH community mental health center (CMHC) and has clinically trained staff. The Mobile Homeless Outreach Team in the Metro Boston Area identifies individuals in need of services and connects them to entitlement programs, case management and other services, and provides psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication compliance.

Employment

Employment services provided by DMH have evolved over time to reflect the growing emphasis on "mainstreaming" clients by helping them find and retain jobs in competitive, independent employment settings. Two successful program models have operated to serve the homeless mentally ill.

Employment Connections I, an interagency project between DMH and the Department of Employment and Training (DET), began serving Metro Boston Area homeless clients in SFY'96. This unique program is housed at Job-Net in Boston, a One-Stop Career Center funded in part by the U.S. Dept. of Labor.

Because Job-Net serves a diverse group of disabled as well as non-disabled job seeking individuals with good as well as problematic work histories, DMH clients receive an integrated job search and placement experience. This has been recognized as a very valuable process.

The Employment Connections program provides job services to clients, and assists them in securing full or part-time jobs. Average wages for clients placed in competitive employment vary widely, ranging from $7.00 to $60.00 per hour.

A new program, the Homework Project, funded by grants from HUD, the U.S. Department of Labor and the Veterans Administration began operations in SFY'04. The goal of the program is to place, house and employ 41 chronically homeless individuals, including 20 with mental illness, over three years. The grantees include DMH and its partners, the Boston Private Industry Council (labor) and the Boston Department of Neighborhood Development (housing).

DMH-funded Community Support Clubhouses and Services for Education and Employment (SEE) programs also provide employment-related services and supports that are accessible to HMI clients. These services include housing placement, vocational training, skill development, educational opportunities (GED, college courses), career planning and development, meals, social contacts and temporary and permanent, part-time and full time job placements.

Rural

Most DMH-contracted Community Support Clubhouses, a type of day program offered to adult clients of DMH, have transportation units. These are member staffed and provide transportation to members in need, both to and from the program as well as to social, cultural and community events.

Adult Community Rehabilitative Support, a program provided in all DMH Areas, includes an emphasis on mobile services to engage potential clients who are resistant to treatment, to assist with and monitor self-administration of medications, and provide skills training and social support services. These programs also assist clients who are unable to receive services in a clinic setting or have difficulty with transportation.

CRITERION IV: ADULT PERFORMANCE INDICATORS

Goal IV/1 A: Provide housing and employment options, and residential services, for individuals with serious mental illness who are homeless

Population: **Adults with serious mental illness**

Objective IV/1 A: **Increase the number of homeless individuals with mental illness that receive residential services**

Brief Name: *Residential services for homeless DMH clients*

Indicator: the number of new homeless DMH clients receiving residential services each fiscal year

Measure: # of *new* homeless DMH clients receiving residential services each year

Year 1: *508 new* homeless DMH clients receive residential services

Year 2: *508 new* homeless DMH clients receive residential services

Year 3: *508 new* homeless DMH clients receive residential services

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
IV/1. *HMI residential services*					
Value: # of new HMI DMH clients receiving residential services each year	**511**	**508**	**508**	**508**	**508**

Objective IV/2 A: **Increase the number of homeless DMH clients working competitively**

Brief Name: *Employment services for homeless DMH clients*

Indicator: the number of new homeless DMH clients working competitively

Measure: # of *new* homeless DMH clients working competitively

Measure: Total # of homeless DMH clients working competitively

Year 1: *10* new homeless DMH clients are working competitively

Year 2: *10* new homeless DMH clients are working competitively

Year 3: *10* new homeless DMH clients are working competitively

Performance Measures:	SFY'03 Actual	SFY'04 Projected	SFY'05 Goal	SFY'06 Goal	SFY'07 Goal
2. *HMI employment services*					
Value: # of *new* homeless clients working competitively	**10**	**8**	**10**	**10**	**10**
Value: total # of homeless DMH clients working competitively	**41**	**49**	**59**	**69**	**79**

Data Source: McKinney and ATARP (Aggressive Treatment and Relapse Prevention) tracking; DMH Data Warehouse, DMH Housing Inventory, the SEE-IS database (Services for Education and Employment Information System), Clubhouse reporting.

Background: DMH homeless initiative dollars are used primarily to provide clinical and residential services and to leverage other resources to fund development or access to housing units. Success of the efforts depends on continued collaboration with advocates, other state and federal agencies and legislative appropriation. "Employment Connections" is supported by a McKinney grant and is a joint initiative with the Department of Employment and Training. Employment services also occur in DMH-funded Clubhouses.

Significance: Targeted residential and employment services to homeless populations are a goal of the mental health block grant.

CRITERION IV: Issues Pertinent to Children and Adolescents

Homeless

DMH and the DPH/Bureau of Substance Abuse Services work with the Institute for Health and Recovery (IHR) to establish local collaborations that support the identification of mental health needs of children who reside in Family Substance Abuse Treatment Shelters with their parents.

In SFY'02, a number of changes occurred in the homeless population that resulted in an expanded role for DMH and its relationship with the Family Substance Abuse Treatment Shelters. To address the root causes of homelessness and the increased numbers of families in hotels/motels, Massachusetts formed a Multi-Agency Action Team (MAAT) that draws upon the expertise and resources of DSS, DMA, DMH, the Department of Transitional Assistance (DTA), DPH, the Department of Housing and Community Development, DOE, and the Housing Assistance Programs.

The goals of the MAAT are: to find appropriate residential settings for homeless families living in hotels; to ensure the development, coordination and implementation of interagency family service plans and follow-up services; and to provide the stability needed to prevent future homelessness. The MAAT operates statewide, with participation from DMH, and at a community level, with consultation available from DMH to DTA, DPH and DSS on an as-needed basis.

The DPH/Bureau of Substance Abuse Services responded to the increased numbers of families in hotels and motels through a new agreement with DTA and DSS. Revised referral criteria were developed for families in the hotel/motel system that ensure direct access to the Family Substance Abuse Treatment Shelters. Families who are seen as amenable to considering substance abuse treatment are now accepted into the shelters. Treatment goals and objectives were changed to address this new population with an emphasis on working with families to sustain treatment gains during and following shelter stays. The number of families in hotels and motels has decreased significantly.

The IHR completed the consultation efforts needed to bring about the above changes. IHR staff with expertise in children's' services were assigned to work with DMH to design a new working agreement with the Family Substance Abuse Treatment Shelters. Since SFY'03, existing agreements in the Southeastern Area have been reviewed, and two new agreements, in the Central Mass. and Metro Suburban Areas were completed. A Children Without Homes Initiative Advisory Committee created a cross-training curriculum that includes the social and emotional developmental needs of children 0 - 5 in the Homeless Family Shelter system.

In addition, youth in transition initiatives have homelessness prevention as a goal. This includes the Youth Development Committee, the Peer Mentoring Project and the proposal submitted to SAMHSA for services to transition-age youth (see narrative under Criterion I for description). DMH also has distributed a DSS curriculum to DMH case managers to teach youth independent living skills and is encouraging its use by providers of flexible support services.

Adult shelters serve individuals 18 and over, which may include adolescents 18-19 who are receiving DMH services. Non-DMH programs for runaway and homeless youth, such as “Bridge Over Troubled Waters,” serve children and adolescents. "Bridge" provides extensive outreach, counseling, day programming, housing and referral services for this population. The City of Boston (Mayor’s Office) and Boston Public Schools also provide services. DMH has formal and informal relationships with these programs and others and accepts referrals from them when the child or adolescent meets DMH eligibility criteria.

The Department’s Homeless Outreach Teams, although focused primarily on working with homeless adults, identify and refer older adolescents who are homeless, and/or members of homeless families, for mental health and other needed services. Typically, DMH child/adolescent staff members are available to assist with referrals of children and/or families.

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Criterion IV: CHILD AND ADOLESCENT PERFORMANCE INDICATORS

Goal IV/1 C/A: Provide support services, as needed, to children and families who are homeless or at risk of homelessness

Population: Children and adolescents with serious emotional disturbance

Objective IV/1 C/A: Increase the number of agreements between Family Substance Abuse Treatment Shelters and the Departments of Mental Health and Public Health.

Brief Name: *Family shelter agreements*

Indicator: the number of shelters having agreements with DMH and DPH

Measure: increase in # of agreements since SFY'04

Year 1: 2 new agreements signed

Year 2: 2 new agreements signed

Year 3: Maintain signed agreements with existing family substance abuse treatment shelters

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'06 Goal**
IV/1 *Family shelter agreements*					
Value: # of signed shelter agreements	**2**	**3**	**5**	**7**	**7**

Data Source: DMH Child/Adolescent Division

Background: Agreements between Family Substance Abuse Treatment Shelters, and DMH and DPH, have been created to strengthen the understanding of mental health needs of youth in the shelters and to provide information about community resources offered by DMH that may be appropriate for shelter families. As a result of this collaboration, staff have information on access to care, psychopharmacological interventions, signs and symptoms of high-risk behaviors, and appropriate use of Emergency Service Programs.

Significance: Assuring that homeless children have access to appropriate mental health services is a goal of the mental health block grant.

CRITERION V: Management Systems

Financial and staffing resources, including human resource development of community mental health providers that will be available to implement the plan. The plan must also describe the manner in which the state intends to expend the mental health block grant.

This criterion has a single narrative of issues common to adults and children. The goals and performance measures at the end of the narrative are age-specific.

Criterion V: Issues Common to Adults, Children and Adolescents

The Department of Mental Health is mandated to target its services to the most seriously mentally ill citizens of the Commonwealth through an array of services providing treatment, support and structured skills development. This array includes inpatient, as well as case management, day/vocational, residential, outpatient and peer and family support services. The goal of the Massachusetts service delivery system is to assist DMH clients to achieve and maintain the highest possible level of functioning so they may live and work in the communities of their choice.

The conceptual framework recognizes that the mental health needs of individuals are unique and change over time. In order to respond to these changing needs, the service system must be flexible, culturally competent, and offer treatment for symptoms of mental illness, as well as rehabilitation and supportive services to assist each individual in coping with the functional disabilities resulting from his/her illness. The Department also recognizes the need to work with families and the community at large to provide a supportive environment.

The estimated SFY'05 state appropriation is *$594.6* million, with *69.5 percent* committed to community-based care. This is an increase of *2.2 percent* over SFY'04. The SFY'05 direct services budget is *$559.2* million, of which *$68.6* million is specifically earmarked for child and adolescent services. Of the total state appropriation, *$145.7* million is targeted for child, adolescent and adult inpatient services in state hospitals (includes three contracted adolescent units), state-operated community mental health centers and one adult contracted extended stay hospital unit.

DMH clients receive services from state-operated and/or vendor-run programs. The majority of the state-operated programs provide continuing inpatient care in state facilities, although inpatient care accounts for only *26.1 percent* of the DMH budget. Most community services are provided through program contracts with providers. As of August 15, 2004, there were SFY'05 contracts in place for *406* adult programs ($275.4 million), *173* for child and adolescent programs ($74.3 million) and *27* for mixed (generic adult/child) services ($9.9 million).

Financial Resources

Revenue generation is a significant factor in supporting the Department's budget. Since 1988, DMH has significantly increased the amount of revenue it generates from its state hospitals, CMHCs and intensive residential treatment programs, as well as from Medicaid Rehab Option and case management services for DMH Medicaid-eligible clients. Estimated revenue in SFY'05 is *$120.4* million, compared with *$8.7* million in SFY'88. With the exception of revenue from the CMHCs, which is retained by DMH in

statutorily created trust funds under the Department's control, and a small retained revenue account for occupancy fees, all other revenue goes to the General Fund (state treasury). However, since the Department's final state appropriation is evaluated by the legislature on a net state cost basis, revenue generation is a significant factor in supporting the Department's budget.

The Center for Medicaid and Medicare Services (CMS) is considering changes in its rules affecting acute care reimbursement (involves federal Medicaid dollars only) to any state or private inpatient facility considered an Institution for Mental Disease (IMD) for patients aged 21-64. This reimbursement is currently available to IMDs in Massachusetts under a federal 1115 waiver. A change in the rules may have a significant impact on revenue generation and future service system design for DMH and for Massachusetts. As of this writing, CMS has not made a final decision on the future of the IMD waiver program and/or what options Massachusetts will have once that decision is made.

Human Resources

At the end of SFY'04, DMH directly employed *3,871* FTEs (compared with *4,265* at the end of SFY'03). This number includes staff reductions resulting from the consolidation of the Department's human resource and revenue functions at the Executive Office of Health and Human Services, a second round of early retirements, and the reconfiguration of some DMH units. DMH continues to work with state-operated facilities as well as vendor-run programs to increase the availability of qualified culturally diverse staff. DMH also provides training for state and vendor staff to provide the knowledge and enhanced skills needed to implement various departmental initiatives.

At the end of SFY'04, DMH had *426* case manager positions. These include adult and child/adolescent case managers as well as eligibility determination specialists.

DMH continues to analyze staff-to-patient ratios in DMH inpatient facilities. Coupled with a revised classification system for inpatient populations, this analysis allows DMH to better review staffing patterns and manpower needs across its facilities, and also is used to support budget and internal resource requests as necessary.

The Department is actively involved in efforts to increase diversity in the workforce, create a workplace that values and respects the individual diversity of staff, and ensure cultural competency in its programs and services. Each Area's Diversity Committee has developed and is implementing a plan to recruit and train staff, support local DMH Cultural Competence initiatives that support and celebrate diversity, and find creative ways to support affirmative marketing programs.

Training

In-service training for staff continues to take place at the local level, including annual statewide training on HIV/AIDS and Infection Control, on new DMH policies as needed, Sexual Harassment, Disaster Training and the Health Insurance Portability and Accountability Act (HIPAA). Four trainings for case managers, on topics identified by the Area training directors, are held each year. DMH also provides difficult-to-treat and psychopharmacology case consultations, upon request, through its Area Medical Directors. Although statewide conferences have been curtailed in recent years due to budget constraints, the Areas continue to hold conferences on topics as varied as cultural diversity, women's issues, health and wellness, elder mental health issues, and ethics. In previous years, DMH provided two annual statewide training conferences in Human Rights, and three annual clinical conferences: one on adult services, one on

child/adolescent services, and one on cultural diversity. DMH continues its commitment to increase diversity in the workforce and create a workplace that values and respects the individual diversity of staff. Each Area's Diversity Committee has a plan to recruit and train staff, and support local DMH Cultural Competence initiatives that support diversity.

In SFY'04, DMH did hold a provider conference and three grand rounds to support its multi-year Restraint Reduction Initiative to reduce restraint and seclusion in child and adolescent inpatient facilities and intensive residential treatment programs. These activities will continue in SFY'05-'07. Providers (DMH-licensed child and adolescent inpatient units) hosted three peer-led roundtables, and also participated, with DMH, in the development of a restraint reduction manual that will be used in ongoing training activities. Finally, after DMH issues new restraint and seclusion regulations in SFY'05, training for all adult, child and adolescent inpatient units/facilities in the state will be conducted. DMH is in the second year of a five-year contract with eight medical school-affiliated programs to train adult, child and forensic psychiatric residents and psychology interns and fellows and meets quarterly with the training directors to ensure fidelity to the training concepts and curriculum expectations in the contract.

Effective intervention requires a coordinated response from all those involved in identifying people with mental illness in the community and those most likely to be involved in a crisis response. Police and emergency room personnel are primary targets for training, with probation officers, hospital security staff, school counselors, community substance abuse treatment providers and emergency medical personnel also invited to attend. The Department of Correction (DOC) requested and received assistance in developing a statewide crisis intervention team, a modified Assaulted Staff Action Program, for all its facilities.

Each of the DMH Areas and/or Sites has developed its own training network and implementation plan. In the Southeastern Area's Taunton/Attleboro Site, for example, cross agency participation in training exercises among those who are likely to interact in emergency situations has been quite successful. Also, a DMH-funded parent coordinator in the Metro Suburban Area has worked with local police to develop a handbook on recognizing and interacting appropriately with adolescents who exhibit behavioral problems.

The DMH Forensic Division provides specialized training for court clinicians, community providers and non-mental health personnel. *Court clinician* training provides foundational education for clinicians involved with both juveniles and adults in the public sector forensic system in Massachusetts. The curriculum, which is supplemented with four videotapes, includes: The Massachusetts Social Service System; Legal Systems; Statutes and State/Federal Regulations; Cultural Awareness for working with forensic populations; Ethical Issues in Adult and Juvenile Forensic Services; Violence Risk Assessment; Expert Testimony; and General Report Writing.

Training for *community providers* and DMH case managers provides knowledge and skills to aid in the treatment and management of clients with histories of violence and criminal involvement. The curriculum includes: An Overview of the Criminal Justice System; Community Management and Treatment of Sex Offenders; Management of Safety and Risk with Persons having Mental Illness and Substance Abuse Issues; and Understanding the Effects of Prison/Jail Culture. For the community providers, there are plans to raise the complexity level of the training, as requested by many on the surveys this past year. Other training topics under consideration are psychopharmacology and

multiple juvenile issues. In addition, risk assessment for violence and threatened violence continues to be an area of concern.

Training for *non-mental health personnel*, in collaboration with DOC, was provided to police, probation, emergency teams, House of Corrections Sheriff's personnel and DOC caseworkers. The content included facts about mental illness, as well as information regarding M.G.L. Chapter 123 and the role of the Forensic Transition Team in release planning.

Improving efficiency and effectiveness

DMH has a Performance Based Contracting (PBC) system that requires providers to report to DMH on agreed upon indicators every six months. This enhances the Department's ability to capture important data concerning the quantity and quality of services actually provided to clients and performance on selected outcome measures, including cultural competence, client satisfaction and dual diagnosis treatment. This automated system permits state providers to enter data directly into the system while contracted vendors must submit the data in writing to the Area, which then enters it into the PBC database.

Block Grant Spending Plan

The block grant represents about ***1.4%*** **of the projected SFY'05 total** (*this number will be finalized when the MOE and Children's Set Aside are completed) support for community mental health services. These funds are targeted to a range of community mental health programs for adults with serious mental illness and children and adolescents with serious emotional disturbance. Services supported by the block grant are an integral part of the community mental health service delivery system and an important means of developing a comprehensive service system for all individuals in need of publicly funded care. The Department was notified in April 2004 that its FFY'04 block grant award was increased by $95,832 to partially offset the previous year's reduction of *$147,744*. As a result, DMH was able to restore some of the previous cuts to "Research" and "Adult Forensic Court Services." The final block grant allocation for FFY'05 is not known at this time. If any additional block grant funds are available in the FFY'05 budget, DMH will apply them to these programs.

The following tables provide a description of state activities under the block grant and a projection of block grant spending for FFY'05. Block Grant funds are awarded on a federal fiscal year basis and the state has two years in which to obligate and expend the funds. Block grant funds are expended on the state fiscal year (SFY) cycle (July 1 to June 30) which differs from the federal fiscal year (October 1 to September 30).

Table One shows the specific services purchased with block grant funds, including child and adolescent services. DMH has allocated *$2.57* million of the grant for FFY'05 for child/adolescent services and continues to comply with the allocation set-aside for these clients. In addition, the state has ensured that when it comes to state expenditures, the level of services allocated for children and adolescents has been maintained.

Table Two indicates the service delivery areas involved. Proposals and contracts for these funds and services will be developed in anticipation of the awarding of the grant.

The administrative component of the block grant is used to support Planning Council activities and perform administrative and accountability functions, such as the development of prevalence estimates and mechanisms for monitoring program accountability and expenditures of block grant funds.

TABLE ONE
FFY'05 PROJECTED BLOCK GRANT
SPENDING PLAN

Program Code	Description	FFY'05 %	Project FFY 05 Funding
		0.00%	
3006	Office Administration	0.72%	$ 61,589
3001	Executive	0.01%	$ 1,000
3007	Program Management	2.25%	$ 193,764
		0.00%	$ -
	Subtotal Administration	2.98%	$ 256,353
3039	Homeless Support Services	0.35%	$ 29,698
3022	Multi-Disciplinary Training	0.46%	$ 39,250
3026	Correctional Mental Health Services	1.05%	$ 90,000
3050	Contracted Adult OutPatient Services	0.00%	$ -
3034	Clubhouse Services	5.75%	$ 494,166
3049	Adult Residential Services	21.08%	$ 1,812,925
3048	Respite Care Services	11.53%	$ 991,187
3036	Services for Education and Employment	6.71%	$ 576,997
3037	Day Rehabilitation	0.00%	$ -
3052	Health/Wellness Initiatives	1.50%	$ 129,000
3056	Individual Support	0.33%	$ 28,583
3058	Family/Caregivers Support	0.00%	$ -
3132	Comprehensive Psychiatric Services	1.00%	$ 86,000
3059	Community Rehabilitative Support	10.27%	$ 883,287
		0.00%	$ -
	Subtotal Adult Services	60.02%	$ 5,161,093
3064	Contracted Child/Adolescent OutPatient	0.00%	$ -
3065	Community & School Support	15.03%	$ 1,292,680
3066	Individual and Family Flexible Support	14.56%	$ 1,252,228
3068	Day Services	0.38%	$ 32,423
3079	Child/Adolescent Residential Service	0.00%	$ -
		0.00%	$ -
	Subtotal Children's Services	29.97%	$ 2,577,331
3015	Client & Community Empowerment	4.66%	$ 400,400
3023	Research	1.33%	$ 114,395
3027	Adult Forensic Court Services	1.03%	$ 88,808
		0.00%	$ -
	Subtotal Mixed Services	7.02%	$ 603,603
	Total Services	100.00%	$ 8,598,380

TABLE TWO
FFY'02 BLOCK GRANT FUNDS SPENDING PLAN
BY AREA

WESTERN MASS AREA
Elizabeth Sullivan, Area Director
P.O. Box 389
Northampton, MA 01061
(413) 587-6295 Total FFY'05 Allocation: $ 430,427

CENTRAL MASS AREA
Elaine Hill, Area Director
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604
(508) 368-3577 Total FFY'05 Allocation: $ 1,508,990

NORTHEAST AREA
Marcia Fowler, Area Director
P.O. Box 387
Tewksbury, MA 01876
(978) 863-5079 Total FFY'05 Allocation: $ 1,505,394

METRO BOSTON AREA
Clifford Robinson, Area Director
20 Vining Street
Boston, MA 02115
(617) 626-9210 Total FFY'05 Allocation: $ 901,978

TABLE TWO
(continued)

METRO SUBURBAN AREA
Theodore Kirousis, Area Director
Westboro State Hospital
Lyman Street
Westboro, MA 01581
(508) 616-3500 Total FFY'05 Allocation: $ 1,868,738

SOUTHEASTERN AREA
Ron Dailey, Acting Area Director
Brockton Multi-Service Center
165 Quincy Street
Brockton, MA 02402
(508) 897-2020 Total FFY'05 Allocation: $ 1,383,199

STATEWIDE INITIATIVES
Ann Detrick, Ph.D.
Central Office
25 Staniford Street
Boston, MA 02114
(617) 626-8071 Total FFY'05 Allocation: $ 999,654

TOTAL: **$ 8,598,380**

CRITERION V: ADULT PERFORMANCE INDICATORS

Goal V/1 A: Provide funds for community-based services

Population: **Adults with serious mental illness**

Objective V/1 A: Increase community services budget.

Brief Name: *Fiscal resources*

Indicator: **the percent of total budget expended for community-based services**

Measure: Adult community program funds
Total DMH direct services budget

Year 1: *61.67*% of the total DMH budget is allocated for community-based services.

Year 2: *61%* of the total DMH budget is allocated for community-based services.

Year 3: *61%* of the total DMH budget is allocated for community-based services.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
V/1. *Fiscal resources*					
Value: % of total direct services budget expended for adult community services	**58%**	**58.3%**	**61.67%**	**61%**	**61%**
Numerator: adult community program funds	**$337.56 m**	**$325.2 m**	**$344.86 m**		
Denominator: direct services budget	**$582 m**	**$557.8 m**	**$559.2 m**	**N/A**	**N/A**

Source of Information: MMARS (Commonwealth database)

Significance: Providing community-based mental health services is a major goal of the mental health block grant.

Goal V/2 A: Ensure that DMH provides culturally competent services.

Population: **Adults with serious mental illness**

Objective V/2 A: Implement the Department's Cultural Competency Action Plan

Brief Name: *Cultural Competency*

Indicator: **annual goals in the DMH Cultural Competency Action Plan are met**

Year 1: A new CCAP is developed and approved; SFY'05 CCAP goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Year 2: *SFY'06* CCAP goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Year 3: *SFY'07* CCAP goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
V/2. *Cultural Competency*					
Value: The DMH Cultural Competence Action Plan (CCAP) is implemented	**CCAP goals accomp-lished**	**CCAP goals accomp-lished**	**New CCAP approved; goals accomp-lished**	**CCAP goals accomp-lished**	**CCAP goals accomp-lished**

Source of Information: Office of Multicultural Affairs

Background: In SFY'99, DMH established and staffed an Office of Multicultural Affairs (OMCA). The office established two professional advisory groups and a Cultural Competence Action Team (CCAT). The CCAT is comprised of individuals from all levels of the DMH organization who are committed to cultural competence and diversity. By the end of SFY'01, OMCA had developed a position paper on cultural competence for DMH, had amended the DMH mission statement to include a commitment to cultural competence, and had produced a three-year Cultural Competence Action Plan (CCAP). In SFY'05, DMH will develop a Plan for SFY'05-'07. This Plan will be reviewed and approved by the CCAT and then sent to the Commissioner for final approval before implementation begins. It is expected that many of the activities, goals and objectives described in the first plan will continue in the next iteration. The DMH Cultural Competence Action Team has been selected to receive a 2004 Commonwealth Citation for Outstanding Performance at a ceremony to be held in the Fall of 2004.

Significance: Ensuring that mental health services are provided in a way that respects the dignity and culture of each individual is a goal of the Department of Mental Health.

CRITERION V: CHILD/ADOLESCENT PERFORMANCE INDICATORS

Goal V/1 C-A: Provide funds for community-based services.

Population: **Children and adolescents with serious emotional disturbance**

Objective V/1 C-A: Increase community services budget.

Brief Name: *Fiscal resources*

Indicator: **Percent of total budget expended for community-based services**

Measure: Child/Adolescent community program funds
Total DMH direct services budget

Year 1: *12.26*% of the total DMH budget is allocated for community-based services.

Year 2: *12*% of the total DMH budget is allocated for community-based services.

Year 3: *12*% of the total DMH budget is allocated for community-based services.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
1. *Fiscal resources*					
Value: % of total direct services budget expended for C/A community services	**12.67%**	**11.66%**	**12.26%**	**12%**	**12%**
Numerator: child & adolescent community program funds	**$73.74 m**	**$65.04 m**	**$68.56 m**		
Denominator: Direct Services budget	**$582 m**	**$557.8 m**	**$559.2 m**	**N/A**	**N/A**

Source of Information: MMARS (Commonwealth database)

Significance: Providing community-based mental health services is a major goal of the mental health block grant.

Goal V/2 C-A: Ensure that DMH provides culturally competent services.

Population: **Children and adolescents with serious emotional disturbance**

Objective V/2/2 C-A: Implement the Department's Cultural Competency Action Plan.

Brief Name: Cultural Competency

Indicator: annual goals in the DMH Cultural Competency Action Plan are met

Year 1: A new CCAP is approved; SFY'05 CCAP goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Year 2: *SFY'06* CCAP goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Year 3: *SFY'07* CCAP goals concerning Community Inclusion, Human Resources, Training and Education, Services, Information, and Data and Research are accomplished.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Projected**	**SFY'05 Goal**	**SFY'06 Goal**	**SFY'07 Goal**
V/2. *Cultural Competency*					
Value: The DMH Cultural Competence Action Plan (CCAP) is implemented	**CCAP goals accomp-lished**	**CCAP goals accomp-lished**	**New CCAP approved; goals accomp-lished**	**CCAP goals accomp-lished**	**CCAP goals accomp-lished**

Source of Information: Office of Multicultural Affairs

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Significance: Ensuring that mental health services are provided in a way that respects the dignity and culture of each individual is a goal of the Department of Mental Health.

STATE MENTAL HEALTH PLANNING COUNCIL LETTER